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the wisconsin medical journal

ESTABLISHED 1903

A Monthly Journal of Medicine and Surgery

with organizational coverage of the medicolegal, socio-economic, ancillary, and public relations aspects in the practice of medicine

Owned and Published by
THE STATE MEDICAL SOCIETY
OF WISCONSIN

Volume 67

JANUARY 1968–DECEMBER 1968

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—Statement authorized by House of Delegates, Oct. 22, 1966

Malpractice—The Layman's Common Medical Knowledge and Experience and Res Ipsa Loquitur

IN A SUIT FOR injuries caused by alleged malpractice, the burden is on the plaintiff to prove the want of reasonable and ordinary care or skill of the physician or surgeon. A physician or surgeon is presumed to exercise his legal duty of ordinary skill and care, and in the absence of proof to the contrary, it is presumed that he carefully and skillfully treated or operated on his patient. No presumption of negligence is to be indulged from the fact of injury, or adverse result of treatment of, or operation on, a patient. Courts, however, may aid the plaintiff in fulfilling his burden by invoking the doctrine of res ipsa loquitur, under certain fact situations. In the recent case of Fehrman v. Smirl, 20 Wis. 2d 1, 121 NW 2d 255 (1963), the plaintiff was operated on for the removal of his prostate gland. The operation resulted in permanent urinary incontinence due to damage to the external sphincter. The Wisconsin court recognized, for the first time, that res ipsa may properly be applied in medical malpractice cases. There are two types of fact situations in which the doctrine may be applied; when a layman is able to say as a matter of common knowledge that the consequences of the professional treatment are not those which ordinarily result if due care is exercised, and where there is no basis of common knowledge for such a conclusion, expert testimony may be a sufficient foundation for it.

This article deals only with what types of fact situations qualify as matters within the common knowledge and experience of a layman.

MALPRACTICE AND RES IPSA LOQUITUR

The standard of care required of a physician or surgeon was enunciated in Ahola v. Sincock, 6 Wis. 2d 332, 94 NW 2d 566 (1958):

> "When a physician exercises that degree of care, diligence, judgment, and skill which physicians in good standing of the same school of medicine usually exercise in the same or similar localities under like or similar circumstances, having due regard to the advanced state of medical or surgical science at the time, he has discharged his legal duty to his patient."

The inauguration of res ipsa loquitur into medical malpractice cases resulted from the logical progression of the law, and a recognition by the courts that certain malpractice cases were not significantly different from those cases in which the doctrine had been applied. Its application arose also, in part, from the realization that the medical profession had become united in the so-called "conspiracy of silence" and as a consequence it became all but impossible to get medical men to testify against each other.

LIMITATIONS OF THE DOCTRINE

Several rather general restrictions have been formulated by the courts with respect to the application of the doctrine in order to prevent excessive "jury speculation." Courts recognize that a doctor's constant contacts are with the frailties, idiosyncrasies, physical and mental weaknesses, and allergies of human nature, which may affect a patient's condition and yet be beyond his control. Morgensen v. Hicks, 253 Iowa 139, 110 NW 2d 563 (1961). Courts also recognize that there are inherent in medical treatment many variables and imponderables which are necessarily beyond the realm of common knowledge and experience. Toy v. Rickert, 53 NJ Super 27, 146 A 2d 510 (1958). Generally, if the defendant is charged with lack of professional skill, discretion or judgment, in which case the question of whether the doctor followed standards recognized by the medical profession would be material, res ipsa is inapplicable. Becker v. Eisenstodt, 60 NJ Super 240, 158 A 2d 706 (1960). The basic limitation imposed on the application of the doctrine is that it will not be allowed merely because the injury is unusual or rare. Fehrman v. Smirl, supra.

The primary objection voiced in opposition to the application of res ipsa is that although there may

Reprinted from the 1964 Annual, PERSONAL INJURY COMMENTATOR, Callaghan & Company, Chicago, Ill., with permission of co-editor, Professor James D. Ghiardi, Marquette Law School, Milwaukee, Wis. Originally printed in the MARQUETTE LAW REVIEW, vol. 47, no. 2, pp. 239–254 (Fall, 1963).

be errors in either procedure or judgment, at the present level of medical intelligence they can be determined only in retrospect, if at all. Consequently, until medical advancement establishes the error and its solution, no duty of prevention should arise. Courts have recognized this problem and will not employ res ipsa merely on the basis of adverse results. Natenson v. Kline, 186 Kan 393, 350 P 2d 1093 (1960). Some courts indulge in mathematical computations, and refuse to apply the doctrine if there is a percentage of unavoidable injuries inherent in the particular type of treatment. DiFilippo v. Preston, 173 A 2d 333 (Del 1961).

In most instances, the courts have remained conservative in allowing the application of res ipsa loquitur. However, in several cases it appears as though the ruling court has blinded itself to the dangers of a liberal application.

CASE ILLUSTRATION

The following is a comprehensive although not exhaustive list of the more recent cases in which the applicability of the doctrine of res ipsa loquitur has been drawn into question. Only those cases which deal with the doctrine on the basis of the ordinary layman's common knowledge and experience are cited.

Anesthesia: In an action against a hospital and a physician for injuries sustained by plaintiff when an explosion occurred within her nasal passages during the removal of a wart from her nose with a hot electric needle, while she was under a nonexplosive anesthetic and before the administration of ether, res ipsa was applied. Dierman v. Providence Hospital, 31 Cal 2d 290, 188 P 2d 12 (1947). The same court applied the rule in a case in which the plaintiff suffered temporary paralysis after she received a spinal anesthetic prior to childbirth. Seneris v. Haas, 45 Cal 2d 811, 291 P 2d 915 (1955). Contra: Porter v. Puryear, 258 SW 2d 182 (Tex Civ App 1953).

The rule has been held not to apply where the machine used to administer the anesthetic explodes, Wilt v. McCallum, 214 Mo App 321, 253 SW 156 (1923), or when the administration of an anesthetic to an intoxicated person causes death, Louden v. Scott, 58 Mont 645, 194 P 488 (1920). An allergic reaction to a particular anesthetic is not grounds for invoking the doctrine. Morgensen v. Hicks, 253 Iowa 139, 110 NW 2d 563 (1961).

Diagnosis: Generally, the doctrine of res ipsa loquitur does not apply in a malpractice case where negligence is charged in diagnosis or treatment. Crovilla v. Cochrane, 102 So 2d 307 (Fla 1958). In a case which involved the diagnosis of cramps in plaintiff's legs, the defendant used an injection of a radio opaque material into his aorta and the plaintiff's lower extremities became paralyzed. The court in Salgo v. Leland Stanford Jr. University Board of Trustees, 154 Cal App 2d 560, 317 P 2d 170 (1957), stated, ". . . aortography and its results, because it is a relatively new diagnostic procedure, is not a matter of common knowledge among laymen. . . ."

Res ipsa has been applied in some cases involving diagnosis, but this is done generally only in peculiar situations, which do not involve the ordinary tort liability concepts.

General practice: Some rather surprising and contradictory rulings have evolved in this area, especially with respect to injections. New Jersey refused to apply the doctrine in a case in which the plaintiff underwent rather severe reactions to an injection of penicillin, Toy v. Rickert, 53 NJ Super 27, 146 A 2d 510 (1958). With a process of reasoning wholly incompatible with the New Jersey court, California has invoked the doctrine under similar circumstances, stating that:

> ". . . it is a matter of common knowledge among laymen that injections in the muscles of the arm, as well as other portions of the body, do not cause trouble unless unskillfully done or there is something wrong with the serum." Bauer v. Otis, 133 Cal 2d 439, 284 P 2d 133 (1955).

It has been held to be common knowledge among laymen that the giving of an enema is not ordinarily harmful unless negligently done. Davis v. Memorial Hospital, 58 Cal 2d 815, 376 P 2d 561 (1962). Res ipsa has been applied when the plaintiff suffered serious burns from a silver nitrate pencil used by the defendant-doctor to outline veins to be removed, Hurt v. Susnow, 192 P 2d 561 (Cal 1948), and where scars were received due to warm compress treatments of a leg which resulted in burns, Milias v. Wheeler Hospital, 109 Cal App 2d 759, 241 P 2d 684 (1953). The application of the doctrine has been rejected in cases involving arsenic poisoning from medicine, Hawkins v. McCain, 239 NC 160, 79 SE 2d (1954), and where a leg was lost as the result of treatment of an injured foot with a tourniquet on the leg. Gallagher v. Kermott, 56 ND 176, 216 NW 569 (1927).

Obstetrics: It has been held to be a matter of common knowledge among laymen that the routine delivery of a child should not result in a paralyzed leg, Ragusano v. Civic Center Hospital Foundation, 199 Cal App 2d 586, 19 Cal Rptr 118 (1962), and that res ipsa was properly invoked when a sponge was left in the uterus following a delivery, Landsberg v. Kolodny, 145 Cal App 2d 158, 302 P 2d 86 (1956). Minnesota applied the rule in a case in which the defendant, following a premature delivery, removed the placenta but left a piece of it which putrified causing blood poisoning, gangrene and loss of a leg, Miles v. McNaughton, 67 Minn 46, 69 NW 480 (1896). When the plaintiff suffers broken bones and crushed vertebra during delivery, res ipsa may properly be invoked, Poor Sisters of St. Francis v. Long, 190 Tenn 434, 230 SW 2d 659 (1950). Serious burns received by a mother due to excessively hot applications during a Caesarean operation also give rise to res ipsa, Timbrell v. Suburban Hospital, 4 Cal 2d 68, 47 P 2d 737 (1935). However, in all these cases, if the injury results from emergency treatment res ipsa is not applicable, McDermott v. St.

Mary's Hospital Corp., 144 Conn 417, 133 A 2d 608 (1957).

Orthopedics: Res ipsa loquitur will not be applied merely because a broken bone fails to heal, Gebhardt v. McQuillen, 230 Iowa 181, 297 NW 361 (1941). However, evidence that the defendant-doctor failed to watch the healing process and to continue adequate treatment has been held sufficient grounds for application of the doctrine, Covington v. James, 214 NC 71, 197 SE 701 (1938). Cases involving casts that are too tightly set are in complete discord. Both Arkansas, Brown v. Dark, 196 Ark 724, 119 SW 2d 529 (1938), and Minnesota, Nelson v. Nicollet Clinic, 201 Minn 505, 276 NW 801 (1937), rejected application of the doctrine when injuries were sustained from tight casts. Iowa has adopted what appears to be a diametrically opposed rule, Daiker v. Martin, 250 Iowa 75, 91 NW 2d 747 (1958).

Failure to set a fracture properly, Olson v. Weitz, 37 Wash 2d 70, 221 P 2d 537 (1950), or to discover by the use of X-ray whether the set is good have given rise to the doctrine, Howell v. Jackson, 65 Ga App 422, 16 SE 2d 45 (1941). However, cases involving the question of how long a cast should be permitted to be worn do not properly give rise to res ipsa, Crouch v. Wyshoff, 6 Wash 2d 273, 107 P 2d 339 (1940).

Psychiatry: It seems to be well settled that res ipsa loquitur is not properly invoked in cases of injuries sustained in the course of electro-shock treatments. Quinley v. Cocke, 183 Tenn 428, 192 SW 2d 992 (1946).

Surgery: This area of medical practice has given rise to the vast majority of litigation, and is perhaps the most difficult area in which to determine the applicability of the doctrine of res ipsa, due to its peculiarly scientific nature. The classic example of the situation in which it is proper to allow an inference of negligence is when a surgical sponge is left in the wound. Dietze v. King, 184 F Supp 944 (ED Va 1960). No inference of negligence arises from the fact that the patient died following a tonsillectomy operation, Sanders v. Smith, 200 Miss 551, 27 So 2d 889 (1946); nor when blindness resulted from an operation on an eye after a magnet failed to remove a foreign body from the eye, Adams v. Boyce, 37 Cal App 2d 541, 99 P 2d 1044 (1940); nor when "foot drop" results from an operation to correct a knee, Engelking v. Carlson, 13 Cal 2d 216, 88 P 2d 695 (1939). The doctrine will not be invoked when a doctor fails to discover that a peg used in a hip pinning operation has moved into the bladder, Meador v. Arnold, 264 KY 378, 94 SW 2d 626 (1938); nor where the defendant unsuccessfully operated to remove a piece of metal and the plaintiff lost his arm, Hunt v. Bradshaw, 242 NC 517, 88 SE 2d 762 (1955). Adverse results from surgery such as scars resulting from the use of clamps, Johnson v. Colp, 211 Minn 245, 300 NW 791 (1941), paralysis of the face after a mastoid operation, Schoening v. Smith, 59 ND 592, 231 NW 278 (1930), or loss of voice after a throat operation, Nelson v. Murphy, 42 Wash 2d 737, 258 P 2d 472 (1953), do not form a proper basis for applying the rule.

A more difficult problem arises when a healthy part of the patient's anatomy which is in close proximity to the injured area is damaged during surgery. In a case where the defendant allegedly negligently sewed a nerve into the soft tissue adjacent to the surgical incision which he had made for a hernia operation, the court stated:

> "The law is well settled that facts relating to difficult surgical operations call for knowledge far beyond the ordinary layman, and resort must be had to testimony of expert witnesses for light on the subject of whether or not the defendant has been guilty of negligence." Richison v. Nunn, 57 Wash 2d 1, 340 P 2d 793, 801 (1959).

However, in a case where the defendant, operating on plaintiff's leg, ligated an artery rather than a vein with resultant gangrene and required amputation, res ipsa was allowed. McGulpin v. Bessmer, 241 Iowa 1119, 43 NW 2d 121 (1950). The doctrine was also applied in a case in which the defendant cut off part of plaintiff's tongue while removing her adenoids. Evans v. Roberts, 172 Iowa 653, 154 NW 923 (1915).

Res ipsa has not been applied when the instrument being used by a doctor in treating a patient breaks and causes injury, Hine v. Fox, 89 So 2d 13 (Fla 1956), or where the patient suffered shocks from an electric-surgical unit used in an operation, Smith v. American Cystoscope Makers, 44 Wash 2d 202, 266 P 2d 792 (1954). California allowed the application of res ipsa in a case in which the defendant removed the uvula and a portion of the soft palate during a tonsillectomy, Thomsen v. Burgeson, 26 Cal App 2d 235, 79 P 2d 136 (1938). Contra: Schmidt v. Stone, 50 ND 91, 194 NW 917 (1923).

Generally, injuries sustained to a healthy part of the patient's body while he is under anesthesia will provide a proper foundation for res ipsa loquitur. Frost v. Des Moines Still College of Osteopathy & Surgery, 248 Iowa 294, 79 NW 2d 306 (1956). The classic case in this area is Ybarra v. Spangard, 25 Cal 2d 486, 154 P 2d 687 (1944), in which the California court allowed application of the doctrine against all the individuals, including the hospital, who had participated in any way in the operation on the plaintiff, after the plaintiff had established that sometime during his appendectomy and while he was anesthetized, he had sustained a traumatic injury to his shoulder.

Res ipsa has also been applied in cases of improper postoperative treatment, as when the doctor uses a caustic which results in burns and disfigurement of the patient's nose, Becker v. Eisenstodt, 60 NJ Super 240, 158 A 2d 706 (1960).

Dentistry: It is a matter of common knowledge and experience that a dentist who removes a healthy tooth, leaving the decayed one in, is not acting with the care and skill required by law, Steinke v. Bell, 32 NJ Super 67, 107 A 2d 825 (1954); and also, that a dentist, as part of his professional duty when

extracting a tooth, should treat the bruised and bleeding socket, Barham v. Widing, 210 Cal 206, 291 P 173 (1930). Res ipsa may be applied when the plaintiff's tooth becomes dislodged and enters her lung, Meyer v. St. Paul-Mercury Indemnity Co., 61 So 2d 901 (La App 1952).

However, in a case in which the plaintiff's jaw was fractured during a tooth extraction, the court held that the proper amount of force to be used was a professional technique which was not within the layman's common knowledge, Bierstein v. Witman, 360 Pa 537, 62 A 2d 843 (1949).

X-ray: The cases in this area seem to be in hopeless confusion. When a burn results from treatment by X-ray machines, the courts are divided. See: Waddle v. Suntherland, 156 Miss 540, 126 So 201 (1930), and Nance v. Hitch, 238 NC 1, 76 SE 2d 461 (1953). When a burn occurs while an X-ray picture is taken of the plaintiff res ipsa may be applied, Jones v. Tri-State Tel. & Tel. Co., 118 Minn 217, 136 NW 741 (1912); but it has been rejected in cases of pictures of teeth, Nixon v. Pfahler, 279 Pa 377, 124 A 130 (1924), and of a heel, Routen v. McGehee, 208 Ark 501, 186 SW 2d 779 (1945). The doctrine has also been rejected in cases involving excessive doses of radioactive cobalt during radiation therapy following a radical mastectomy, Natenson v. Kline, 186 Kan 393, 350 P 2d 1093 (1960).

LESSON DERIVED FROM CASES

A cursory study of these examples reveals that what constitutes "common knowledge and experience" is by no means common knowledge itself. It is not unusual to find two courts in utter disagreement over an identical fact situation. All courts professedly use the same standards and tests, but unlike medicine which is substantially the same everywhere, the law varies from jurisdiction to jurisdiction. This diversity in the application of the doctrine illustrates the existence of the danger that laymen may be permitted to exercise and apply their own "medical" diagnoses to different factual situations.

TRIAL COURT

Initially, the question of whether the jury is competent to pass judgment on the actions of a physician or surgeon is in the discretion of the trial court, for it must determine whether or not to submit the case to the jury.

RULES FOR APPLICATION OF RES IPSA LOQUITUR

The examples and general rules cited in this article provide several helpful guidelines and tests that may be employed by the trial court in making its determination as to whether the cause should be submitted to the jury. Briefly, the factors that should be considered are:

1. Is the question of the defendant-doctor's use of the proper degree of skill and care essential?
2. Was the injurious result merely unusual and rare?
3. Is there an established, unavoidable percentage of risk involved in the procedure in question?
4. Is it a question of proper diagnosis?
5. Did the injury result from the application of a newly discovered method of treatment or diagnosis?
6. If the injury resulted from surgery, was the operation complex and involved, or was the injured portion of the plaintiff's anatomy located in close proximity to the area being operated upon?

If one or several of these factors applies to the case under consideration, the trial court should be reluctant to allow the plaintiff a chance of recovery under res ipsa unless he can and does establish his case by expert testimony. This may seem like a harsh, overly restrictive test that defeats the purpose of allowing the application of res ipsa loquitur; but it must be borne in mind that this doctrine is not meant to be a substitute for affirmative evidence. Rather, it is intended to aid the plaintiff in submitting his evidence, and to eliminate the necessity of positive evidence where a valid inference of fact lies. An unwarranted application of res ipsa gives rise to the danger of imposing a form of strict liability upon a physician when his patient experiences adverse results from his treatment, since an instruction on the doctrine is apt to be allotted greater significance by the jury than is intended.

CONCLUSION

This decision creates a judicial Pandora's box. If the permissible use of the doctrine is extended too far the lid on the box will be opened and the evils of the rule will abound. However, as was true in mythology, this Pandora's box does provide one desirable feature; res ipsa loquitur will permit an injured party to be compensated in those patently obvious situations that heretofore may have gone uncompensated due to the difficulties experienced in meeting the requisite degree of certainty of proof in establishing the cause of action, and due to the "conspiracy of silence."

Editor's Note: Several cases dealing with the applicability of res ipsa loquitur in medical malpractice cases on the basis of a layman's common knowledge have been recently decided. In Stone v. Proctor, 131 SE 2d 297 (NC 1963), the plaintiff suffered a crushed vertebra after undergoing the first of several electroshock treatments. He complained of severe pain, but the defendant-psychiatrist failed to take any X-rays to determine the source of the pain. The court held that the "Standards of Electroshock Treatment" prepared by the Committee on Therapy and approved by the Council of the American Psychiatric Association, of which the defendant was a member, afforded a sufficient foundation for submission of the case to the jury. At page 300 of the opinion the court stated:

"The 'Standards' with which the defendant was familiar and which he could and apparently should have observed, required X-ray investigation. This requirement the defendant failed to observe, although he knew that fractures result in 15 to 30 per cent of the cases in which the treatment is administered. The foregoing are permissible inferences which the jury may or may not draw from the evidence. For the court to draw the inferences would invade the province of the jury."

In Gerhardt v. Fresno Medical Group, 31 Cal Rptr 633, — P 2d — (1963), the plaintiff underwent surgery for the removal of a lymph node in her neck. When she awoke from the anesthesia her right arm and shoulder were sore and difficult to move. Testimony established that the result was extremely rare, and not an inherent risk in the operation, and that the injury was due to the crushing of the spinal accessory nerve in the neck. On this basis the court allowed the application of res ipsa loquitur. In Horner v. Northern Pacific Benefit Ass'n Hospitals, Inc., — Wash 2d —, 382 P 2d 518 (1963) the court stated:

"Surely, to emerge from abdominal surgery with a paralyzed arm is so extraordinary an occurrence within the general observations of mankind as to raise an inference of negligence that requires both an explanation and proof of nonnegligence to meet. It may well be that surgery to or manipulation of a part of the human anatomy will normally produce drastic symptoms in other parts of the body not related to the situs of such surgery or manipulation, but, if so, we may be sure that this could readily be proved."

In this case the plaintiff underwent a hysterectomy operation which resulted in paralyzation of her right arm. In Lipman v. Lustig, — Mass —, 190 NE 2d 675 (1963), the court overruled a directed verdict in favor of the defendant-dentist, in an action brought by the plaintiff for injuries sustained when a reamer was dropped down her throat. The plaintiff had produced no expert testimony.

For additional articles related to this subject which have appeared in the Personal Injury Commentator see: Malpractice Hazards in Dental Extractions, 1961 Annual, p 142; Medical-Legal Relations—The Brighter Side, 1958 Annual, p 30; Court Dictation of Choice of Anesthesia, 1958 Annual, p 81; Evidence in a Malpractice Case, 1958 Annual, p 167; Evidentiary Problems in Proving Radiation Injury, 1958 Annual, p 200; The Use of Expert Evidence in Res Ipsa Loquitur Cases, 1958 Annual, p 279; Medical Malpractice and Res Ipsa Loquitur, 1960 Annual, p 340; Overcoming the "Conspiracy of Silence": Statutory and Common-Law Innovations, 1962 Annual, p 177; Res Ipsa Loquitur in California Medical Malpractice Law —Expansion of a Doctrine to the Bursting Point, 1962 Annual, p 250; and, Siverson v. Weber—A Reconsideration of Res Ipsa Loquitur in Medical Malpractice, 1963 Annual, p 181.

* * *

EDITORIAL COMMENT: Subsequent to the reprinting of the above article, the Wisconsin Supreme Court has implemented the tools of plaintiff's counsel by two specific rulings.

In *Surpit v. Brah*, 30 Wis. (2d) 388, 141 NW (2d) 266, it has been held that plaintiff's counsel may now cross-examine a defendant-doctor and obtain his opinion; and,

In *Lewandowski v. Preferred Risk Mutual Ins.*, 33 Wis. (2d) 69, 146 NW (2d) 505, the court approved the practice of permitting medical texts material to be introduced as evidence.

Immunization Information for International Travel, 1967–68 Edition

A copy of the booklet "Immunization Information for International Travel," revised July 1967, is available. Previous issues of the booklet and any supplements should be destroyed.

Changes in immunization requirements occurring before the next issue of the booklet will be listed under the item "Quarantine Measures" in the *Morbidity and Mortality Weekly Report*, published by the National Communicable Disease Center. Persons not receiving this report may write to the Editor to be placed on the mailing list.

Additional copies of the booklet may be obtained from the Superintendent of Documents, Government Printing Office, Washington, D. C., 20402, at 40¢ a copy. There is a discount of 25% for 100 or more copies delivered to the same address.

The revisions include: (1) information concerning smallpox vaccinations or revaccinations performed on or after January 1, 1967, which must be recorded on the revision of the International Certificate of Vaccination or Revaccination against Smallpox approved by the 18th World Health Assembly; (2) an up-to-date map of the Yellow Fever Receptive Areas in the United States, Section 8; (3) current information on immunization requirements for entrance to other countries, Section 5; (4) changes in recommendations concerning typhoid, tetanus, plague and diphtheria immunizations, Section 2; and, (5) the change in the smallpox vaccination requirement for persons traveling between the United States and Mexico.—ARTHUR S. OSBORNE, Medical Director, National Communicable Disease Center; Chief, Foreign Quarantine Program

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THIS JANUARY BLUE BOOK ISSUE of the Wisconsin Medical Journal contains a variety of articles relating to medicolegal matters of direct concern to the physician. While a number of these articles are reprinted from previous Blue Book issues, there are some which are new. Articles reprinted have been updated where applicable, particularly the article concerning Workmen's Compensation. Your attention is called to the following new articles appearing in this issue:

- **Malpractice—The Layman's Common Medical Knowledge and Experience and Res Ipsa Loquitur**
- **The Abused Child Law**
- **Joint Commission Standards Governing Hospital Privileges for Podiatrists**
- **Control of LSD**
- **Recent Changes in Self-Employed Retirement Plans**
- **Tax Deductibility of Health and Accident Insurance**
- **The Professional Corporation in 1967**
- **Joint Commission Standards for Dentistry in Hospitals**
- **Directory, Wisconsin Legislature**
- **Organizational Chart of the Department of Health and Social Services (formerly the State Board of Health and the Department of Public Welfare)**

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The Professional Corporation in 1967

I. HISTORY AND BACKGROUND

SINCE 1932, the Internal Revenue Code has contained, unchanged, statutory definitions of partnerships and corporations. They are as follows:

> "(2) PARTNERSHIP AND PARTNER.—The term 'partnership' includes a syndicate, group, pool, joint venture, *or other unincorporated organization*, through or by means of which any business, financial operation, or venture is carried on, and *which is not*, within the meaning of this title, a trust or estate or *a corporation;* and the term 'partner' includes a member in such a syndicate, group, pool, joint venture, or organization. (Emphasis supplied)
>
> "(3) CORPORATION.—The term 'corporation' includes *associations*, joint-stock companies, and insurance companies." (Emphasis supplied)

Until the beginning of World War II in the early 1940s, corporate income tax rates were high and individual income rates were relatively low. The revenue interests of the federal government during the 1930s were therefore best served by having as many organizations treated as corporations as possible. Accordingly, the Internal Revenue Service sought to treat as associations as many partnerships, including medical partnerships, as it could, so as to apply the higher corporate income tax rates instead of the lower individual rates.

In 1936, in the case of *Pelton v. Commissioner* (C.A.—7th), 82 Fed. 2d. 473, the Circuit Court of Appeals in Chicago upheld the contention of the Internal Revenue Service that an organization of physicians was an unincorporated association and should be treated as a corporation for federal income tax purposes, even though a corporation could not practice medicine in Illinois.

The Circuit Court of Appeals based its decision on the theory that the organization of physicians had in fact more of the characteristics of a corporation than it did a partnership. The four characteristics that it considered were: (1) the centralization of management, (2) the continuity of the partnership life, despite the death or withdrawal of one or more partners, (3), the limitation of personal liability for liabilities of the partnership, and (4) the right of the individual members of the organization to transfer freely their interests in it.

On the basis of the *Pelton* decision, a number of partnerships, voluntarily or involuntarily, were treated as associations and therefore taxed as corporations by the federal government.

World War II caused a switch in the federal income tax rates, and for the first time individual rates became higher than corporate rates. Concurrently, the 1942 Revenue Code, for the first time, recognized deferred compensation plans, such as profit sharing and pension plans, for employees. Officers or stockholders who were employed by corporations were allowed to participate in these plans the same as any other employee. The contributions to the plan which were made by the corporation on behalf of the officers or stockholder employees, were deductible as a business expense by the corporation on its income tax return, and the employee was not compelled to report such contributions as income currently on his income tax return.

The result of these changes in the federal income tax law, when coupled with the rationale of the *Pelton* case, now made it desirable for some medical groups to seek association status, and thereby achieve corporate income tax status and employee status for the physician members of the medical group.

In the now famous case of *United States v. Kintner*, (C.A.—9th) 216 F. 2d. 473, the Internal Revenue Service reversed its position and sought to tax the unincorporated association of physicians as a partnership, rather than as an association taxable as a corporation. The court, in that case, rejected the government's reversed position, cited the *Pelton* case with approval, and held that the association was taxable as a corporation. This case was decided in 1954.

In 1959, in *Galt v. United States*, 175 Fed. Supp. 360, (N.D.—Texas), the District Court again held an unincorporated association of physicians taxable as a corporation, despite the contrary arguments of the Internal Revenue Service. The Treasury Department was also unsuccessful in the *Foreman* case, which was tried in the District Court of Florida.

The Internal Revenue Service did not agree with or follow any of the decisions cited above, but instead, in 1959, attempted to amend the Code by issuing a set of proposed income tax regulations which would have the force of law, and the effect of making it practically impossible for the attainment of corporate status by medical partnerships. These regulations were finalized in November 1960, and were felt by most tax practitioners to be contrary to the interpretations of the Internal Revenue Code by the courts in the *Pelton*, *Kintner* and *Galt* cases.

These 1960 regulations in part provided that *local law* (state law) would be applied in determining the relationship of the professional person to his business organization. If an organization was a partnership under general state non-tax law, it would be a partnership for federal income tax purposes. Accordingly, professional organizations in more than 30 states went to their state legislatures and asked

for the adoption of state laws authorizing the formation of corporations and associations for the practice of their professions. These laws were expressly drawn so as to make it possible for a professional group to organize in such a manner that they could comply with these 1960 Regulations and thereby become taxable as corporations.

Wisconsin was one of the first states in which professional organizations sought and secured legislation in 1961. The professional corporation statute of this state requires that such a corporation provide for capital stock which may be held only by the members of the particular profession which organizes it. No person outside that profession is allowed to purchase any of its stock. All directors and officers of the corporation must be members of the same profession.

In reliance on these laws, corporations and associations were organized by professionals in these various states. It is estimated that more than 100 professional corporations alone have been established in this state since 1961. Pension plans and profit sharing plans were adopted, and contributions were made to these plans by the associations and corporations. Many applications were made to the Treasury Department for approval of corporate status and approval of the profit sharing and pension plans. The Treasury took no action on any of them. Furthermore, several groups precipitated a legal test of the issue by filing partnership returns, paying the tax for the partners, and then suing for a refund. The Treasury did not defend these cases, but instead refunded the tax in question so that there would be no issue for the court to pass on.

Finally, in December of 1963, the Treasury Department proposed a whole new set of regulations, and these were finalized in February of 1965. The gist of the revised regulations is that no professional group which has organized under state statutes allowing professionals to form corporations or associations will be recognized by the Treasury Department as a corporation, and, therefore, the profit sharing and pension plan benefits will not be recognized for the professional person either. The new regulations did recognize as corporations, for federal income tax purposes, those professional corporations and associations which were organized and filed corporate income tax returns in 1964 and prior years.

Unlike the 1960 Regulations, which were directed at *un*incorporated associations, those of 1965 were directed at *in*corporated organizations, despite the clear language of the Revenue Code itself, which says

> "The term 'partnership' includes a syndicate, group, pool, joint venture, or other *un*incorporated organization . . . which is *not* a *corporation*."

The first case involving professional corporations since the promulgation of these 1965 regulations has recently been decided by the Federal District Court of Colorado. The opinion in the case of *Empey v. United States* was dated August 31, 1967. The Court held the 1965 Regulations to be invalid, and did so by stating that the clear language of the Internal Revenue Code itself was that a partnership included only *un*incorporated organizations and that any *in*corporated organization must be treated as a corporation for federal income tax purposes. It also cited with approval the rationale and holdings in the *Pelton*, *Kintner*, *Galt* and *Foreman* cases.

The federal government has filed an appeal in the *Empey* case. Whether it will perfect its appeal remains to be seen.

The *Empey* case is, of course, not binding as a judicial precedent in the Wisconsin Federal District Courts, or in the 7th Circuit Court of Appeals, which hears appeals from Wisconsin district courts. Especially in the absence of contrary federal court decisions, it is reasonable to anticipate that the *Empey* case will be carefully considered by the federal courts of Wisconsin.

The Treasury, by its own admission, indicated that as of June 7, 1967, there were four additional cases pending in various district courts around the country. As of mid-December, none of these cases is known to have been decided.

II. TAX BENEFITS OF PROFESSIONAL CORPORATIONS

1. Income Tax

Since all of medical practice fees are paid to the professional corporation, this permits the corporation to pay *less than all* of its net income to the physician members, and to pay the balance to a separate tax-exempt profit sharing retirement trust. Thus the physicians do not have as much personal taxable income, and their individual income taxes are correspondingly reduced.

The balance of net income not paid to a physician member of a professional corporation is deductible for income tax purposes by the corporation when paid by it to the profit sharing trust.

Thus, no tax is paid on this balance and the tax saving to the physician is whatever his top income tax bracket would have been had he received this sum instead of having it paid by the professional corporation to the profit sharing trust.

The amount paid by the corporation to the tax exempt profit sharing trust must be allocated to all, or nearly all, employees, including others than physicians. But, because this allocation can be made in the ratio of the respective salaries received by the employees including physicians, the physicians having by far the greater percentage of these aggregate salaries, also have by far the greater percentage of profit sharing trust contribution allocated to them. Thus, while the tax saving is somewhat diluted by this allocation to nonphysician employees, the greater part of the tax saving continues to inure to the benefit of the physicians who comprise the professional corporation.

As a broad generalization, a successful professional corporation will generate income at suffi-

ciently high levels so that there is likely to be some saving in Wisconsin income taxes as well as in the federal. The state saving will typically be substantially less, but should not be minimized.

In addition, the profit sharing trust being itself tax exempt, all capital gains and all interest and dividend receipts of the trust are income tax exempt.

The benefits are taxed when received from the profit sharing trust by each employee at time of his retirement, or severance of employment, or by his beneficiaries at time of death. However they can be taxed at no higher than 25% of the benefits, this being treated as long-term capital gains if all of the benefits are received in one year. The income tax benefits of a profit sharing trust, as compared with private investing can be illustrated best by the approximate figures shown in the following computation:

Comparison of Privately Investing $1,000 (Reduced by Income Tax) Annually Compounded at 4%, with Investing $1,000 Annually in a Profit Sharing Plan Compounded at 4%

Number of Years	Investment in Profit Sharing Trust		Less Capital Gain Tax		Net	Private Investment Various Tax Brackets 50%	60%
5	$ 5,400	less	$1,350	=	$ 4,050	$ 2,500	$ 2,000
10	12,000	less	3,000	=	9,000	5,400	4,250
15	20,000	less	5,000	=	15,000	8,500	6,600
20	29,000	less	7,250	=	21,750	12,100	9,200

2. Death Tax

In addition to the income tax benefits described above, a substantial death or estate tax benefit is also available. Any benefits paid by the profit sharing trust upon the death of an employee to his beneficiaries is exempt from the federal death tax. The typical physician's estate will have a federal estate tax bracket of about 15% if he has a surviving wife, or approximately 30% if his wife has predeceased him.

By way of example, if the benefits paid to the deceased physician's beneficiaries amount to $100,000, the saving in federal death tax alone would amount to either $15,000 or $30,000, as the case may be.

III. PROFESSIONAL CORPORATIONS vs. H.R. 10 (KEOGH LAW) SELF EMPLOYED PLANS

While H.R. 10 self employed profit sharing and pension plans do provide some tax benefits, there are major features of professional corporation profit sharing and pension plans which are not available under the H.R. 10 self employed type plan.

The maximum amount which can be contributed for any one owner employee in an H.R. 10 plan is $2500, or 10% of earned income, whichever is less. In a professional corporation profit sharing plan, the limitation is 15 percent of the employee's compensation, no matter how high the compensation goes. For example, in a professional corporation profit sharing plan a physician whose salary from the professional corporation was $50,000 per year could have $7500 contributed, tax free, to the plan, whereas he would be limited to $2500 under H.R. 10.

Second, capital gains treatment of benefits on severance of employment or death, is not available in H.R. 10 plans. Instead an averaging device is substituted, which, depending upon a number of other factors, will produce a result somewhere between ordinary income treatment and capital gain treatment.

The death benefits paid from an H.R. 10 plan are not exempt from federal death tax as they are in the case of a plan created by a professional corporation. There are a number of other differences which make the H.R. 10 plans somewhat less desirable. Furthermore, the method of operation with regard to H.R. 10 plans is much less flexible even during the years during which the employee is working before retirement.

IV. EFFECT IF CORPORATE STATUS NOT ACHIEVED

If the corporation were ultimately treated by Internal Revenue Service and the courts as a partnership, a major effect would be that the contributions made to the profit sharing trust by the corporation for the benefit of the physician employees would not be deductible by the corporation but instead would be treated as having been just as though the corporation were a partnership and therefore these contributions to the plan would be taxed to the individual physicians. A tax would therefore be payable on these contributions. Insofar as this tax is concerned, however, the taxpayer would be no worse off than he would have been had he not set up the profit sharing plan in the first place.

Interest, however, is payable on any tax determined to be due which is not paid on time. A three year statute of limitations is in existence, and interest at the rate of 6% is chargeable. The interest is on the amount of tax, not on the amount of the profit sharing contribution. The real effective rate, after tax, of interest in the case of a 50% top bracket income taxpayer is only 3%, interest being a deductible item.

Furthermore, the corporation would have spent money for legal and accounting fees in setting up the corporation and profit sharing plan. These, however, should also be deductible as abandoned reorganization expenses, so that the real cost to a 50% taxpayer would only be 50%.

There would be of course litigation expense if the professional corporation and its physician-employees chose to fight the matter of professional corporation status.

Lastly, the lay employees' accounts in the profit sharing trust would be fully vested and could not

be returned to the corporation or the physicians. In effect the employees would have gotten a raise in compensation which belongs to them.

V. TO INCORPORATE OR NOT TO INCORPORATE?

It would seem that whether or not to incorporate is a business decision. In making this decision, each medical group must compute (a) its annual tax benefits, (b) the projected death tax savings, and (c) tax-free compounding of earnings, and weigh these against what they will stand to lose in the way of interest and litigation costs which will be payable if the matter is contested.

As a broad generalization, the creation of a professional corporation is probably not warranted unless there is strong likelihood that the income generated, barring ill health or other similar contingencies, will produce a surplus beyond the reasonable needs of the organizers. If, for reasons of personal need or preference, those earning the income desire to spend it all, the profit sharing savings device which is so important a part of the professional corporation would have no useful function to serve.

If the economic gain possibilities substantially outweigh the costs of litigation and interest, it would seem that professional incorporation would be a good business risk. Each group, however, should make its decision on whether to incorporate only after a painstaking analysis of the overall situations of all physicians involved.

If we can correctly assume that most courts will uphold corporate income tax status for professional corporations on the basis of finding the regulations invalid, and that an organization which is called a corporation by state legislature shall be taxed federally, as a corporation, then it would seem that the sole practitioner and the two physician partnerships should also have no features which would make incorporation for them any more risky taxwise than for groups of three or more.

Joint Commission Standards Governing Hospital Privileges for Podiatrists

THE JOINT COMMISSION on Accreditation of Hospitals in its Bulletin No. 44, for April, 1967, tells how the governing body of an accredited hospital may grant hospital privileges to a qualified podiatrist.

In Wisconsin, the practice of podiatry is defined by section 154.01 (1) of the Statutes as

> ". . . the diagnosis or mechanical, medical or surgical treatment, or treatment by the use of drugs, of the feet, but does not include major surgery or the use of a general anesthetic. Diagnosis or treatment shall include no portion of the body above the feet except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg insofar as they shall be involved in the conditions of the feet."

RELATIONS WITH STAFF PHYSICIANS

Under Joint Commission standards, the qualifications of each podiatrist who applies for hospital privileges must be evaluated by the Medical Staff. The individual podiatrist's professional education, training, experience and competence, and his demonstrated character and judgment should determine the degree to which hospital privileges will be granted him.

The privileges granted to a podiatrist do not make him a member of the Medical Staff.

The podiatrist may initiate the procedure for admitting a patient, but the admission may not be completed without the concurrence of a member of the Medical Staff.

That concurring Staff member thereupon becomes responsible for the overall care of the patient. The patient's physical examination and medical history are primarily within such overall care, but the podiatrist may participate, within his area of practice, in these functions.

Any podiatric surgery must be supervised by a member of the Medical Staff having surgical privileges. That Staff member in each case shall determine the nature and the degree of his participation in the surgery. He should consider, among other things, the exclusion of major surgery and use of general anesthesia from the practice of podiatry as defined in Wisconsin law.

BYLAWS

Bylaws for each hospital which grants privileges to a podiatrist should establish for the podiatrist the same general qualifications, the same terms and procedures of appointment, and the same general ethical standards as apply to members of the Medical Staff. In addition, the bylaws should specify that the podiatrist is governed by the Principles of Ethics of the American Podiatry Association.

Rules and Regulations of the Medical Staff should apply to the podiatrist also, but the Joint Commission's Bulletin lists the following two additions as having special application to the practice of podiatry within the hospital:

"a. As in all surgical cases, an adequate medical history and physical examination by a member of the Medical Staff shall be required on each patient before surgery. Consultation with the Medical Staff shall be required when medical complications are present. A qualified member of the Medical Staff must be responsible for the care of any medical problems that may be present or arise during hospitalization.

"b. Complete records, both podiatric and medical, shall be required on each patient and shall be a part of the hospital records."

DUAL RESPONSIBILITY THE KEYNOTE

Dual responsibility of the staff physician and the podiatrist with hospital privileges is the keynote of the Joint Commission's standards in this area. In the words of the Bulletin,

"It is reiterated that every podiatric inpatient must have a physician with appropriate medical staff privileges who is available and will be responsible for the overall aspects of the patient's care through the hospital stay."

QUESTIONS AND ANSWERS

1. May a podiatrist admit and discharge his cases?

Only in conjunction with a member of the Medical Staff under policies governing admission and dismissal which should be clearly stated in the Medical Staff By-Laws.

2. Who writes the history and physical?

Both—the podiatrist is responsible for his field and will write the podiatric history and physical and its implications on the patient's general health; the physician the medical history and physical. An adequate medical survey by a member of the Medical Staff shall be required on each podiatric patient before surgery.

3. Who writes the progress notes and summary?

Both, if necessary, though if the case is primarily podiatric, it is presumed that the podiatrist will write the bulk of the chart, and vice versa if the case is primarily medical.

4. Can a podiatrist prescribe narcotics* or systemic drugs?

Prescription of orally and parenterally administered drugs, including narcotics, within the hospital, is a question of judgment for the physician assuming overall care of the patient and should depend upon the qualifications and training of the podiatrist, the physician's assessment of his capability and the complexity of the case.

5. May an intern or resident write the medical history and physical examination?

Yes, if this procedure has been approved by the hospital and is in accordance with the Joint Commission policies on this point.

6. Must a physician be "scrubbed in" when a podiatric case undergoes surgery?

This is a question of judgment for the physician-surgeon assuming appropriate responsibility with the podiatrist for the patient and should depend upon the qualifications and training of the podiatric surgeon, the physician-surgeon's assessment of his capability and the complexity of the case.

7. When a patient is admitted for podiatric surgery does a member of the medical staff or a member of the surgical staff assume appropriate responsibility with the podiatrist?

In this instance a physician-surgeon member of the active staff who has been accorded surgical privileges would assume the responsibility for the patient's overall care.

8. What is meant by the term "overall care"?

The term overall care means overall medical responsibility. In an accredited hospital only a physician-surgeon who is a member of the active Medical Staff of the hospital may assume this responsibility.

9. Does the term "overall care" as utilized in the statement of hospital privileges for podiatrists mean dual responsibility?

Yes, this is explained under the title "dual responsibility". The podiatrist will be responsible for his area of practice as defined, and the physician-surgeon member of the Medical Staff will assume the overall medical responsibility for the patient's care throughout his hospital stay.

From BULLETIN NO. 44, for April, 1967, of the Joint Commission on Accreditation of Hospitals.

* EDITOR'S NOTE: Under Wisconsin law, a podiatrist may not prescribe narcotics.

The Right to Use the Title "Doctor" in Wisconsin

HISTORICALLY, the title "doctor" has been conferred upon those who have become so well versed in a particular field of knowledge that recognized schools of higher education regard them as qualified to teach the subject. Among the long-established doctoral degrees are those in medicine, dentistry, divinity, law, science, philosophy, letters and music.

TRADITIONALLY, when the treatment of the sick was involved, the title "doctor" has referred to the doctor of medicine.

The legal right to use the title "doctor" outside the field of treating the sick is not discussed. Obvious examples are doctors of divinity, veterinary medicine, or philosophy, so long as none of them is engaged in "treating the sick," as this term is defined in Wisconsin.

THE WISCONSIN statutes and court interpretations are controlling on who may use the title "doctor" when "treating the sick."

The following is a summary of the present law of Wisconsin as it applies to use of the title "doctor" when engaged in "treating the sick." This is accompanied by brief references to the legal authority supporting the conclusions. It is assumed in each instance that the practitioner has fulfilled licensure or other requirements imposed by Wisconsin law.

Subsections (a) and (b) of Sec. 147.01 (1) of the Wisconsin Statutes, 1965, provide:

> "(a) To "treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.
>
> (b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts."

LEGAL AUTHORITY

The following is a summary of the principal statute or court decision which is the basis of the conclusions reached in the chart below and which follows the same order as the chart:

1. **Physician:** The right of a doctor of medicine to use the title without restriction is conferred by Sec. 147.14 (3), Wisconsin Statutes, which provides:

> "(3) No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under s. 147.17, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M.D." "D.O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick."

2. **Osteopath:** Controlled by the above subsection and, therefore, unlimited.

3. **Dentist:** The right of a licensed doctor of dental surgery to use the title without restriction is conferred by Sec. 152.02 (1), Wisconsin Statutes, which provides in part:

> "(1) Any person who was lawfully engaged in the practice of dentistry in this state on January 1, 1939, may so continue if he has registered annually. . . . No other person shall practice dentistry in this state, unless he is licensed by the board and annually registered in this state. . . . Any person is deemed to be "practicing dentistry"

SUMMARY OF WISCONSIN LAW ON USE OF TITLE "DOCTOR"

Practitioner	Unrestricted Right to Public Use	No Right to Public Use When Treating Sick
1. Physician	X	
2. Osteopath	X	
3. Dentist	X	
4. Podiatrist (Chiropodist)	X	
5. Chiropractor		X
6. Optometrist		X
7. Doctor of Philosophy (when treating the sick)		X

within the meaning of this chapter who . . . uses or permits to be used, directly or indirectly, for a profit or otherwise for himself, or for any other person, the title or appends to his name the words or letters "doctor," "Dr.," "Doctor of Dental Surgery," "D.D.S.," or "D.M.D.," or any other letters, titles, degrees, terms or descriptive matter, personal or not, which directly or indirectly represent him to be engaged in the practice of dentistry. . . ."

4. **Podiatrist:** (Chiropodist) The right of a registered podiatrist to use the title without restriction is conferred by Sec. 154.01 (2), Wisconsin Statutes. This provides in part:

"(2) No person shall practice podiatry, for compensation, directly or indirectly, or in the expectation thereof, or attempt to do so, or designate himself as a licensed podiatrist, or use the title "D.S.C.," "Dr.," or "Doctor of Surgical Chiropody," or "Doctor of Podiatry," or "Doctor," or "foot doctor," or "foot specialist" or other title or letter indicating that he is a podiatrist, or otherwise directly or indirectly represent or hold himself out as such, unless registered by the state board of medical examiners . . ."

5. **Chiropractor:** No statute relating to chiropractic authorizes the use of the title "doctor" or initials "Dr." or "D.C." by a chiropractor. The illegality of the use of either the title or the initials "D.C." is based upon Sec. 147.14 (3) quoted earlier in Section 1. of this article, inasmuch as chiropractors "treat the sick."

In *State v. Michaels* (1938) 226 Wis. 574, the Supreme Court, in an opinion written by Chief Justice Rosenberry, forbade a chiropractor to use the title "doctor." The opinion stated, at pages 578 and 579, that since 1881 the use of the word "doctor" had been restricted by the Wisconsin legislature, and that the right to use the term had become associated with those entitled to practice medicine, surgery, and after 1903 osteopathy.

With reference to the statute regulating chiropractic, which was amended in 1925 to require licensure, the court stated at page 579 of the above opinion:

"The statute was rewritten and revised to make it clear that those practicing chiropractic could not hold themselves out as a doctor or append to their names the title of doctor because, in Wisconsin at least, that would tend to represent them as a doctor authorized to practice medicine, surgery, or osteopathy."

6. **Optometrist:** An optometrist practicing in Wisconsin is *not* entitled to use the word "doctor," the title of "Doctor of Optometry," or the initials "O.D." in the course of his practice. Chapter 153 of the Wisconsin Statutes deals with optometry. It is completely silent on his right to use the title or any variation of it. Authority must, therefore, be sought outside that chapter. In *Nickell v. State* (1931) 205 Wis. 614, at pages 617–618, the Supreme Court held that the examination of human eyes by various mechanical means constituted "treating the sick" under the Wisconsin Statutes. That decision has not been modified by subsequent opinions of the Supreme Court, or by later legislation. The essence of the practice of optometry is the examination of human eyes by such mechanical means. Therefore, the use of the title is controlled by and forbidden under Sec. 147.14 (3), Wisconsin Statutes, quoted in Section 1. of this article.

7. **Doctor of Philosophy:** There is no Wisconsin court decision authorizing *any* doctor of philosophy, including a psychologist, to make public use of his title when treating the sick. It is clearly controlled and prohibited by the provisions of Sec. 147.14 (3) quoted in Section 1. of this article.

As the Rosenberry opinion stated so appropriately as to the use of the title "doctor" by chiropractors in the *Michaels* case, cited in Section 5. of this article, at page 580 of that decision:

"The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment."

In the somewhat earlier case of *Corsten v. Industrial Commission* (1932) 207 Wis. 147, the court concluded its discussion of the meaning of Sec. 147.14 (3), quoted earlier, with the following sentence which appears at page 149 of the decision:

"Thus these names and letters may be applied only to those who are licensed as physicians to practice medicine and surgery, and conversely those to whom the names and letters may not be applied are not physicians."

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Reference: Sections 155.05 and 966.121, Wisconsin Statutes, 1965.

Medical Evaluation of Driver Impairment

THE DRIVER should be required to submit evidence of his functional capacity if he has a medically definable physical condition or process which may give rise to a lapse of consciousness, loss of postural control, loss of vision while driving, or any other physical or mental impairment that may be objectively identified that results in loss of ability to control his vehicle with safety. *It is the symptom which is the matter of concern and not the condition or process per se.*

A. BASIC PRECEPTS

1. Safe motor vehicle operation requires coordination of a complex series of sensory inputs, judgmental decisions, and neuromuscular motor responses. Driver impairment may involve any of these areas of human function.
2. Driver impairments may be temporary or permanent—deteriorating, static, or improving. Permanent impairments may warrant revocation of the operator's license; temporary impairments usually must be managed by education of the driver to recognize his limitations so that he may modify his driving as necessary.
3. The physician in his evaluation of possible driver impairment must frequently make judgments which are unpopular with the driver who is faced with possible loss of his operator's permit; but the revocation decision is not made by the physician, this responsibility rests with the Motor Vehicle Department.
4. There are many apparently serious physical impairments to which satisfactory compensatory adjustments may be effected and drivers with these problems are frequently able to demonstrate competence in a driving test.
5. Persons subject to unexpected, sudden lapses of consciousness or of neuromuscular control cannot be considered safe drivers and must be urged to give up driving, at least until the underlying cause is under medical control. Present law in Wisconsin does not provide for physician reporting of these "impaired" drivers.
6. There is no evidence that age alone is a justifiable criterion for definition of ability to drive safely. Many young (inexperienced) drivers have impairment of their driving abilities by reason of immature judgment; some elderly drivers have driving impairment by reason of sensory and/or motor deficits resulting from the aging process.
7. Many driver impairments are of such a nature that safe motor vehicle operation may be reasonably assured in restricted traffic situations —i.e., daylight hours, low to moderate speeds, low traffic volume.
8. Many drugs, including alcohol, produce temporary impairments which may cause severe functional limitation; all driving age patients using certain drugs—especially tranquilizers, sedatives, narcotics, antihistamines, stimulants, and mood modifiers—must be warned of the possible dangerous effects of the medicines and advised to restrict their driving accordingly. NOTE: Attention is called to the *potentiating effect of alcohol* in combination with many of these drugs.

B. SPECIFIC MEDICAL CONDITIONS OR AREAS

DIABETES . . . The uncontrolled diabetic should be advised not to drive because of the possible sudden development of disabling complications.

HYPERINSULIN STATES . . . Individuals subject to attacks of faintness, giddiness, or unconsciousness should not drive.

THYROID DISEASE . . . Uncontrolled thyrotoxicosis should be considered a contraindication to driving, also severe myxedema and cretinism.

MUSCLE WEAKNESS AND HYPOTONIA . . . Individuals with these symptoms of various metabolic and/or neurologic conditions may need to be advised to restrict or stop their driving.

CARDIOVASCULAR DISEASE . . . Uncontrolled conditions in which sudden death, lapse of consciousness, or pain sufficient to cause loss of control of the vehicle should preclude motor vehicle operation.

CEREBROVASCULAR DISEASE (INCLUDE HYPERTENSION AND VASOMOTOR INSTABILITY) . . . Patients with inadequate blood flow to the brain are likely to have attacks of syncope or dizziness (vertigo) and should be advised not to operate a motor vehicle.

VISION . . . Optimally corrected vision poorer than 20/40 in the better eye should be considered to be cause for restricted driving; corrected vision of at least 20/70 should be required for restricted driving privileges. Color blindness is not now considered to be of any great consequence to safe driving.

Prepared by the Commission on Safe Transportation of the State Medical Society and approved by the Council, Oct. 21, 1966.

HEARING . . . Hearing loss can be compensated for to enable safe driving. Present state law requires outside rear-view mirrors for these drivers.

SKELETAL (ORTHOPEDIC) DEFECTS . . . Acute musculoskeletal injuries frequently produce temporary driver impairment; chronic and permanent defects frequently may be compensated for by special mechanical devices and should be subjected to the test of "demonstrated competence" to drive safely.

CONVULSIVE DISORDERS . . . Current Wisconsin Statutes are considered to provide adequate safeguards for the general highway public as well as to allow the privilege of the highway to the person whose condition is controlled. Night driving may present particular hazards of "photic stimulation of seizures" of which the driver should be advised.

NARCOLEPSY . . . Persons with this condition should be allowed to drive if it is controlled by medication and medical supervision is maintained.

MENTAL DEFICIENCY . . . Drivers need to have the intellectual capacity, demonstrated by testing, to interpret the basic traffic control signs and to react appropriately. This determination is a function of the licensing authority and borderline applicants should probably have restricted privileges.

MENTAL AND EMOTIONAL DISTURBANCES . . . There are presently no known testing procedures which can reliably predict a person's ability to drive safely or to indicate a significantly hazardous emotional instability such as to warrant consideration for license revocation; certainly many mentally ill persons have periods of functional impairment but these, for the noninstitutionalized person, should be handled as are other temporary impairments. Individuals who have had changes in personality, alertness, ability to make decisions, or actual loss of motor or sensory power, should not be allowed to drive until the condition is stabilized and competence can be demonstrated by appropriate testing.

ALCOHOLISM . . . Chronic alcoholics should not drive until such time as there is reasonable medical evidence that the condition is controlled.

C. SUMMARY

The presence of certain physical pathologic processes or conditions should give rise to a question of fitness to drive. This brief guide has been prepared in an effort to inform the examining physician of currently accepted concepts of anatomic and functional aspects of driver impairment.

D. SUGGESTED REFERENCES

1. AMA Medical Guide for Physicians in Determining Fitness to Drive a Motor Vehicle, 1959.
2. Proceedings National Conference on Medical Aspects of Driver Safety and Driver Licensing, 1964 (out of print).
3. Special Report—Medical Aspects of Driver Limitation, JAMA, Feb. 1, 1964, p. 376.
4. Drugs and Driving, JAMA, Jan. 31, 1966, pp. 376–379.

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: Section 255.02 (2), Wisconsin Statutes, 1965.

CAN YOU PRACTICE WITHOUT A LICENSE?

The practice of medicine and surgery within this state requires a license. Even physicians just finishing their military service or moving to Wisconsin from another state *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to criticism or disciplinary action.

Temporary licenses may be granted under special circumstances by the State Board of Medical Examiners. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practice in this state.

Reference: Sections 147.14(1), 147.15(2), 147.19, Wisconsin Statutes, 1965.

What Every Doctor Should Know about Workmen's Compensation

VIRTUALLY every physician practicing in Wisconsin becomes involved with treatment of a patient covered by Workmen's Compensation. This law provides payment of compensation for disability and expense for medical attention necessary because of injury sustained in the course of and arising out of employment.

Furthermore, a physician or any other employer except a farmer is presently subject to the Workmen's Compensation Act if he has three or more employes in the course of his trade, business, profession, or occupation.

Effective January 1, 1969, a physician or any other employer except a farmer will become subject to the law if (1) he usually employs three or more employes or (2) he pays wages of $500 or more in any calendar quarter subsequent to July 1, 1968, covering services within Wisconsin. An employer subject to the Act must have Workmen's Compensation insurance coverage, which can be obtained from any insurance company authorized to do business within Wisconsin.

Please contact either the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, or Ralph E. Gintz, Administrator of the Workmen's Compensation Division, Hill Farms State Office Building, Box 2209, Madison, Wis. 53701, if you have any questions.

Five points of advice will aid every physician in dealing with Workmen's Comp.:

★ Have your name listed on the State Medical Society's Workmen's Compensation panels if you want to treat employes under Workmen's Compensation.

★ Learn how to estimate disability according to the standards set up by the Department of Industry, Labor, and Human Relations (formerly the Industrial Commission). Other standards or schedules are fine for your own information, but only the Department's standards are authoritative in Wisconsin.

★ Submit your reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. Quite often the unexpected misfortune places the employe in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

★ Don't be afraid to ask questions. Contact either the State Medical Society or Ralph E. Gintz at the addresses noted above.

The following article provides answers to the questions most commonly asked of the State Medical Society in its past 31 years of experience with the Workmen's Compensation Act.

Q. Since the Workmen's Compensation Act is designed to provide protection to the working men of Wisconsin, how does the physician get into the picture?

A. When a workman has, or thinks he has, an injury or disease resulting from his employment, a report from the employer or a claim by the workman is filed with the Workmen's Compensation Division. To establish this claim a medical report verifying and specifiying the workman's injuries or diseases and the degree of disability is necessary. The Workmen's Compensation office and the employer or insurance company use the doctor's disability report to help determine the amount of compensation. If it turns out that the employer is obligated to provide or pay for necessary medical attention, he is required to supply the injured employe with "such medical–surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial members, appliances . . . as may be reasonably required to cure and relieve from the effects of the injury."

Q. How does the Workmen's Compensation Division determine whether the claim is justified?

A. Three essential elements must be ascertained before an award can be made to an injured claimant. They are an employer–employe relationship; the employer must be subject to the Act; and it must be proved that the injury or disease was suffered or acquired in the course of employment.

Q. Can any physician treat employes under the Workmen's Compensation Act?

A. Any licensed physician, as a general rule. The Workmen's Compensation Act requires the employer to maintain a "reasonable number" of competent and impartial physicians ready to undertake the treatment of his employes and to permit the employes to make a choice of their physicians from among them.

Prior to 1939 a great many companies had limited panels. However, during that year the State Medical Society of Wisconsin and the insurance companies selling workmen's compensation insurance in the state entered into a joint agreement to enlarge the panels through the voluntary cooperation of employers and the insurance companies. The object was to give the workmen of Wisconsin an opportunity to secure virtual free choice of physician.

This agreement has come to be called the "Open Panel System." Any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employes may have his name included on the panel, which is prepared for each county in the state. These panels are certified to the insurance companies and are distributed to each employer of three or more persons in the state. This system has been so successful that more than 80% of the workmen in Wisconsin now have a wide choice of physicians.

Q. How does a doctor get on the panel?

A. About every three years the State Medical Society of Wisconsin circulates each of its members. The doctor is asked if he wants to be listed on the panel. If he completes the form and returns it promptly, he will automatically be listed on the next panel. However, a physician may at any time request listing or removal. The panels will not be changed until the next printing, but inquiries directed to the office of the Society will be answered on the basis of the current participation of each member.

Q. Does the doctor take on any obligations if he applies for a listing on the panel?

A. Yes. He agrees to have consultation when this is requested by the insurance carrier. He also agrees to communicate with the insurance carrier on the matter of choice of the consultant so that the consultant might be mutually agreed upon. Some exceptions will occur to these agreements, but the exceptions should be limited only to emergencies.

Q. Are any other practitioners listed on the "Open Panel"?

A. No. The State Medical Society panel lists only members of the State Medical Society. If any panel distributed by an insurance carrier contains the names of any other persons, it is not a panel approved by the State Medical Society.

Panels are distributed by another group of unlimited licensees, but these are not part of the State Medical Society program.

Q. What happens in the event of dispute or complaint about the handling of certain cases?

A. Under the "Open Panel" agreement a "State Conference Committee" is set up. It includes two representatives of the insurance carriers and two representatives of the State Medical Society. The duties of this committee are to mediate, if possible, cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary, cases where insurance carriers are charged with having unreasonably interfered with what is properly in the discretion or control of the attending physician, and differences that may arise between the attending physician and the insurance carrier relative to remuneration; to review any situation in which it is claimed there is a violation of ethics; and to hear complaints relative to the competency of those serving on the panel and remove their names from it if an investigation shows that such complaints are justified. Cases involving medical ethics will be referred to the board of censors of the appropriate county medical society. Local committees may be designated to investigate and report back to the "State Conference Committee" with recommendations when it seems necessary. Mediation will be attempted only in cases in which the physician involved is on the listing provided by the State Medical Society.

Q. How is the physician paid for services rendered to an injured workman who is covered under the act?

A. Usually the employer or his Workmen's Compensation insurance company pays the physician. This is true where it is conceded that the injury was sustained on the job and that the treatment rendered was necessary because of such injury.

Where there is a dispute and it is found that the case is not covered by the Workmen's Compensation Act, the employer is still liable for treatment authorized by him. On the other hand, the employe–patient is liable for unauthorized treatment. The Workmen's Compensation Division determines what treatment is covered under the Workmen's Compensation Act.

Q. What about other situations?

A. Where the employer fails to furnish a panel, the injured employe has complete free choice. Then the Workmen's Compensation Division has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible.

Sometimes the employe does not give notice of his injury or the necessity for treatment, or he refuses to accept the panel physician. In that event the employer or insurance company may not be liable.

Q. Are the claim reports filed by the physician kept confidential?

A. As a general rule communications from a patient to an attending physician are privileged. The Workmen's Compensation Act creates an exception to the law of privilege. The law provides that any physician attending a Workmen's Compensation claimant furnish to the employe, the employer, the Workmen's Compensation insurance carrier or the

Workmen's Compensation Division information and reports relative to a compensation claim. The Division explains that it is a practical necessity for physicians to furnish information. Physicians will not be required to disclose confidential communications transmitted to them unless such information is necessary to a proper disposition of the claim. The physician's testimony should be absolutely fair, factual and unbiased.

Q. Does this mean that the physician need not divulge any information to the employer about an employe who files a claim?

A. The physician most certainly is not required to disclose information communicated to him by the employe when it goes beyond the information required for a proper disposition of a claim. However, under the Workmen's Compensation Act, the employer, the insurance company, or the Workmen's Compensation Division has the right to request a complete report on an injured employe. So, as a matter of fact, the physician may legally transmit to the employer such information as is required for a proper disposition of the claim. He is not privileged to release any other informaton than that ordinarily required for the handling of the claim.

Q. What is the doctor's role in disputed cases?

A. Naturally, there will sometimes be disputes between the employe and the employer or his compensation carrier as to whether the workman has suffered an injury in the course of his employment for which he is entitled to compensation. The physician may be asked to act as an expert witness for either the injured workman, the employer, or his insurance company. Therefore, doctors must be interested in whether the injury or disease was suffered in the course of employment and arose out of the employment.

When the employer or his insurance company agrees to the fact that the injury or disease was due to the employment, the question then is confined to the extent of liability on the part of the employer. In many instances this means the physician must be prepared to explain the disability in terms of its effect on the employe.

Q. What about "outside" physicians appearing as expert witnesses?

A. Sometimes the injured workman calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such cases the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully. The Workmen's Compensation Division is authorized in the interest of a fair and impartial hearing to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians are witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Q. How much is paid as a witness fee when physicians testify?

A. Ordinary witness fees are paid unless the physician performs work in preparation at the request of one of the parties to the dispute. In those cases in which the physician appears as an expert witness for the injured employe, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Workmen's Compensation Division will endeavor to protect the employe through permitting only what it considers to be a reasonable allowance for the expert witness. Each bill necessarily depends on the circumstances of the individual case. The State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness. With an itemized statement before it, the Division is in a better position to judge the work involved and the reasonableness of the charges of the physician.

Physicians must also keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employe for payment. Likewise, where a physician treats an injured employe, and such treatment has not been authorized by the employer, and the Division finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Q. Must a physician obey a subpoena when only ordinary witness fees are paid?

A. Yes. Some physicians believe that they cannot be required to obey a subpoena unless an expert witness fee is paid to them. This is erroneous. Wisconsin courts have held that, except where there is a demand for preparation, every witness, expert or otherwise, must obey a subpoena upon payment of the ordinary witness fee.

Q. Are there special procedures for the handling of compensation claims of state employes?

A. In a sense, yes. The Division is particularly explicit in its demands for itemized medical statements and for verification of the reasonableness of the medical charges in the case of state employes who file compensation claims.

Such cases require a report (on a form supplied by the Division) from the attending physician, showing the nature of injury and the extent of disability. In addition, the physician and/or hospital must provide an itemized bill showing services rendered and charges made.

In any case in which disability results or medical expense is involved, a statement is required from the employe (on a form supplied by the Division) to the effect that he was injured in the course of his

employment, reciting time and place of injury, the reasons for its occurrence, and the nature of injury, and stating all expenditures incurred for medical, surgical, and hospital treatment and medicines to the time of the claim, whether the claim is made for disability and, if so, what period of temporary disability and what permanent disability is claimed, and what salary has been paid by the state during the period of disability. If bills have been paid by the injured, receipts are to be attached.

Further, these cases require a statement from the employing department stating whether injury occurred in the course of employment and whether treatment is believed necessary as claimed. This will be made in conjunction with the employe's statement and on the same form. If the department is unable to make a statement, the reason is to be stated.

Q. Can you explain non-schedule injuries?

A. Non-schedule injuries are those to some portion of the body other than the legs, arms, ears, or eyes, or their constituent parts. In other words, non-schedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

Permanent disability for such injuries is estimated on the basis of the comparison between the nature of *the injury* and the nature of *an injury* causing permanent total disability of the entire body as a working unit.

Q. Now what is meant by schedule injuries?

A. Schedule injuries are estimated upon a different basis which bears no relation to wage loss. In these cases *the comparison is between the injured limb and a normal limb,* having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes, and ears, as well as any constituent part of these members and organs. Disability is measured as a percentage loss of use as compared to amputation at a designated joint or joints or, in the case of the eye or ear, as a percentage loss of use compared to total loss of sight or hearing.

The estimate of disability has no reference to any particular occupational use to which the member is to be put. For example, the violin player who has lost a digit vital for the purpose of playing may consequently lose a great deal in wages. However, he receives exactly the same number of weeks compensation as does the laborer who may be able to perform his work nearly as efficiently as before even with the loss of a digit.

The law fixes the value of each finger, thumb, toe, hand, arm, foot, and leg at various joints. In the estimation of disability the physician takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists. If disability is between joints, he considers the percentage of loss of function at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the injured arm with a normal arm at the elbow or, put conversely, with an arm which has been amputated at the elbow.

In every case of schedule injury where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases. Therefore, the estimate in such cases should be uniform. If the employe has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted. In case of schedule injuries the Workmen's Compensation Division has adopted a guide table for disability due to losses of motion.

Q. Is there anything to help the physician in rating disabilities?

A. Yes. The Department of Industry, Labor, and Human Relations worked closely with the State Medical Society and physicians in establishing a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In this guide, for example, where the loss of the function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20% of the arm at the shoulder.*

Elements of disability include amputations, limitation of motion, pain, weakness, lack of endurance, and deformity. The disability is the percentage loss of use as compared to amputation at the affected joint or joints. When amputation is between joints, the loss is 100 per cent at the amputated joint, plus the percentage of bone loss at the next phalanx as determined by comparative x-rays. This is the loss for amputation and additional disability rating may be due for additional disability factors of the remaining portion of the limb. The Division can determine the percentage of disability because of loss of motion from its guides, but the physician's opinion must be given as to the percentage of loss at each joint or joints that are affected for other elements of disability.

In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. If, for example, in addition to limitation of motion, there is disabling pain and/or weakness, a percentage must be added for these elements. The physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability. It should be clearly indicated at what joint or joints the disability is measured.

Physicians should submit their reports promptly. Delay may mean withholding of compensation to the injured employe and of professional fees to the physician.

Q. What if the physician disagrees with these methods of estimating disability?

A. Most parties are in general agreement as to the essential justice of the current provisions. Obviously, the physician's methods of estimating must be in accordance with the law regardless of his personal feelings as to the correctness or justness of the law. Any feelings that the law is harsh, inadequate, or inequitable in certain individual cases should never be allowed to influence the physician either in treating or in estimating disability.

Q. Should the doctor suggest the basis for settlement?

A. No. The physician who estimates disability should never concern himself with the result in number of weeks or in dollars. He should confine himself strictly to the medical field in estimating the disability on a functional basis. It is the function of the employer and the carrier, not that of the doctor, to propose the basis for settlement. The doctor's function is to report his factual findings with the probabilities and possibilities which may be involved, leaving to the employer or carrier the suggestion as to whether or not settlement should be made and upon what basis. Obviously, the physician should not be influenced by the amount of compensation which may be paid to the injured.

Q. Does the physician have any part in the computation of compensation?

A. Physicians should not attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than a particular physician might consider to be equitable. Computation of compensation based on estimates of disability is a function of the Workmen's Compensation Division. The attempts of physicians to compute sometimes result in erroneous figures and cause confusion and misunderstanding, both on the part of the physician and the injured person.

Q. In estimating disabilities in the schedule group, would 50% loss of motion mean 50% loss of function of the limb?

A. No, not necessarily. Loss of use and loss of motion are not identical. All functions of the limb, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, and so forth, must be considered. The physician must assign to each factor the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member. Also, to each factor must be applied the percentage of loss of motion of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

When disability consists of loss of motion of a finger, the physician need not convert the degrees or percentage loss of flexion or extension into loss of use as shown by the guide on page 25, since the Division can do this from the information supplied. The physician should clearly set forth the degrees or percentage loss of flexion and/or loss of extension at each joint of each finger that is affected. Normal extension is in a position of 180 degrees at all joints. Normal flexion at the distal joint of the finger is taken to be 70 degrees in the absence of any indication to the contrary. At the second or middle joint, normal flexion is considered to be 100 degrees and at the proximal 90 degrees. For example, a 30-degree loss of extension at the middle joint is 30% loss of extension rather than 16%, which many physicians often indicate. This is true because 30% loss of extension must be a percentage of the total motion of the joint, in this case the middle joint, which has only 100 degrees of motion.

Q. What kind of forms are used in reporting disabilities under the Compensation Act?

A. The Division has adopted special forms for use of physicians. If the Division is to pass upon a disability, it is necessary that the physician's report contain all of the information requested on this form as a basic minimum. If for some reason the form is not used by the physician, he should make certain that the requirements of the form are met. This will save returning the form to the physician with a request for supplementary report.

Q. If the physician completes the form properly, does this eliminate the need for him to personally appear in cases before the Division?

A. Over 90% of all injury claims are paid by the employer or insurance company without dispute and on the basis of reports submitted. Where dispute arises and formal hearing becomes necessary, the Division has a type of physician's report form which may eliminate the necessity of having the physician appear personally. The law provides that the contents of certified or verified medical and surgical reports by physicians licensed in and practicing in Wisconsin presented by claimants for compensation shall constitute prima-facie evidence as to the matter contained therein, subject to such rules and such limitations as may be prescribed. Likewise, reports of physicians and surgeons, wherever licensed and practicing, to whom

Guide for Estimating Permanent Disabilities Under Workmen's Compensation

The following guide represents percentages of loss of use for losses of motion as compared with amputations at the involved joints.

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90°, but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Total ankylosis of arm at elbow at right angles	
With radio-ulnar motion intact	50%
With radio-ulnar motion destroyed (hand 45° less than fully pronated)	70%
Ankylosis of arm at elbow at 45° less than full extension with radio-ulnar motion intact	45%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis	Mid-position	Complete Extension
Thumb		
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle, and proximal joints	100%	100%

Fingers

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10%	= 1%	10%	= 2%
	20%	= 2%	20%	= 4%
	30%	= 3%	30%	= 6%
	40%	= 5%	40%	= 8%
	50%	= 10%	50%	= 15%
	60%	= 15%	60%	= 20%
	70%	= 20%	70%	= 30%
	80%	= 25%	80%	= 40%
			100%	= 60%
Middle joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 10%
	40%	= 25%	40%	= 15%
	50%	= 40%	50%	= 30%
	60%	= 50%	60%	= 50%
	70%	= 60%	70%	= 70%
	80%	= 70%	80%	= 90%
			100%	= 100%
Proximal joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 15%
	40%	= 20%	40%	= 20%
	50%	= 25%	50%	= 25%
	60%	= 30%	60%	= 40%
	70%	= 35%	70%	= 75%
	80%	= 40%	80%	= 85%
			90%	= 100%

Thumb

Distal joint same as for fingers.

Proximal joint 40% of the loss of use indicated for fingers.

Hip

Ankylosis in alignment for normal standing position	50%
Shortening of leg (no posterior or lateral angulation, age 50 or less)	
1 inch	7%
1½ inches	14%
2 inches	22%

Knee

Ankylosis at 170°	40%
Limitation of motion, remaining range 135°–180°	20%

Ankle

Ankylosis — favorable position 10°–15° equinus without loss of inversion and eversion	30%
Ankylosis—favorable position with loss of inversion and eversion	40%
Loss of inversion and eversion with full dorsi and plantar flexion remaining	15%

the claimant has been sent for examination and treatment by the employer or insurer, are available for evidence provided the doctor consents to subject himself to cross-examination. The use of the form mentioned above makes it unnecessary for the physician to appear personally in some cases, especially where the issue and dispute is of a simple nature and it is desirable to avoid expense to the applicant in arranging for the personal appearance of the physician at the time of the hearing.

Q. Are special forms used in cases of loss of vision?

A. Yes. These forms will be supplied to physicians upon their request, along with rules for determining loss of visual efficiency caused by industrial injury.

Q. Are there any special forms for estimating loss of hearing?

A. In cooperation with the medical profession, insurance carriers, industry, and labor, the Division has worked out formulas for determining the loss of hearing suffered during the course and as a result of particular employments. These formulas are a guide at the present time and are primarily for the assistance of the examining physician. Copies of the formulas and associated material may be obtained by writing the Workmen's Compensation office.

Q. Are there any suggestions for completing the forms required?

A. A full report covering all factors is necessary to be able to fix the percentage of disability. Therefore, the doctor should set out in detail the elements which constitute disability. He should state as nearly as possible the weight and percentage of loss which has been ascribed to each. He should also set out his opinion as to the ultimate total percentage of disability which has resulted. This enables the Division to check the report with its standards and to arrive at an intelligent and uniform conclusion.

Q. What about terminology?

A. Many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring and little fingers, and to disability at the distal, second, and proximal joints. Some physicians refer to the first, second, third, and fourth fingers, and some designate the thumb as the first finger. Some physicians speak of the interphalangeal joints, and sometimes of the first, second, and third joints, leaving confusion as to the point of measurement. The law designates distal, second, and proximal joints. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reports can be avoided.

Q. Can a physician use his own standard for measurement of disability?

A. Only those adopted and published by the Department of Industry, Labor, and Human Relations itself should be considered as authoritative or as representing the Department's thought as to percentages of disability based on certain functional losses. Obviously, physicians will have various ideas as to standards and schedules for estimating disability. However, they should use these as a matter of interest. Their opinions should be based upon their own examination and analysis and by reference to the standards which the Department has adopted.

Q. To whom should the physician furnish reports with regard to a compensation claim?

A. Regardless of any other statutory provisions, the law specifically provides that any physician attending a Workmen's Compensation claimant may furnish to the employe, employer, Workmen's Compensation insurance carrier, or the Division information and reports relative to a compensation claim. It further provides that a physician from outside Wisconsin may testify in compensation proceedings if he is licensed for the place of his residence or practice.

Q. How does a physician get the needed report forms?

A. Simply write to the Workmen's Compensation Division, Hill Farm State Office Building, Box 2209, Madison, Wis. 53701.

Q. Where can the physician go for additional help in handling compensation cases?

A. The Workmen's Compensation Act and its administration is necessarily highly technical. The panel physician will find it easier to deal with the employer, the insurance carrier, and the patient if he has a reasonable understanding of its operation. Both the office of the State Medical Society and the Workmen's Compensation Division stand ready to assist in solving some of the problems facing the physician who treats patients entitled to or claiming benefits under the act. Inquiries may be directed either to the State Medical Society, Box 1109, Madison, Wis. 53701, or to Ralph E. Gintz, Administrator of Workmen's Compensation, Hill Farm State Office Building, 4802 Sheboygan Avenue, Box 2209, Madison, Wis. 53701.

1967 RECOMMENDED MINIMUM EMPLOYMENT STANDARDS FOR REGISTERED PROFESSIONAL NURSES IN WISCONSIN

Copies of this booklet are available upon request from the Wisconsin Nurses Association, Inc., 161 West Wisconsin Avenue, Milwaukee, Wis. 53203; or tel. (area code 414) 272-3670.

The Abused Child Law

How It Affects You

Abuse of children by parents and others can be found at all economic, educational and social levels. The cumulative effect of repeated beatings or other forms of severe abuse, which may include physical crippling, brain damage or even death, must be prevented.

The 1965 Legislature strengthened the prior law making reporting of suspected cases of child abuse mandatory, and adding to physicians and surgeons as the persons who are required to report, nurses, social workers and school administrators. The 1967 Legislature added dentists and hospital administrators to those persons required to report. The Legislature further provided that the reports could be made to the city police departments in lieu of the sheriff and granted civil as well as the criminal immunity from suit where a report is made in good faith.

The actions of the Legislature have immeasurably increased the probabilities that perpetrators of abuse will be identified and will receive rehabilitative help while the abused child will be extended protection from further abuse.

The Law

The law, as it will read in the 1967 statutes is set forth in full as follows:

48.981 Reports On Abused Or Injured Children. (1) A physician or surgeon being of the opinion as specified in s. 885.21 (1) (f), or a nurse, hospital administrator, dentist, social worker or school administrator having reasonable cause to believe that a child brought to him or coming before him has had physical injury or other abuse inflicted upon him by another, other than by accidental means, shall orally report the same and the facts and circumstances forming the opinion. The report shall be made immediately by telephone or otherwise, and followed by a report in writing to a county child welfare agency specified in s. 48.56 (1), the sheriff of the county or the city police department. The recipient of the report shall notify the other receivers of reports within forty-eight hours. When the recipient of the report is the sheriff of the county or city police department, he shall make an investigation consistent with the facts and circumstances described in the report and take whatever emergency action is necessary for the protection of the child. If the sheriff or city police department determines that legal action is necessary he shall refer the case to the district attorney for criminal prosecution. The county child welfare agency specified in s. 48.56 (1) shall investigate each report and act in accordance with its powers and duties as set forth in s. 48.57.

(2) Anyone, in good faith, participating in the making of a report pursuant to this section or participating in a judicial proceeding resulting therefrom shall in so doing be immune from any liability, civil or criminal, that might otherwise be incurred or imposed.

(3) Anyone knowingly and willfully violating this section by failing to file a report as required, may be fined not more than $100 or imprisoned not more than 6 months or both.

Your Responsibility

Physicians and surgeons, nurses, hospital administrators, dentists, social workers and school administrators may make their initial reports in any expeditious manner to the county welfare department, the county sheriff or the city police department. However, follow up reports must be in writing to the agency first contacted.

There are no legal requirements for the form of the written report. It may be a letter stating salient points of the individual case, or it may be merely a note or cover letter that accompanies copies of the medical findings and case history. Where x-rays reinforce the initial diagnosis of the battered child, physicians and surgeons and dentists should incorporate such findings in their reports. It is recommended by the Department of Health and Social Services that the report also contain:

1. The names and addresses of the child and his parents or whoever is caring for him;
2. The child's age;
3. The nature of the child's condition, including any evidence of previous injuries or disabilities;
4. Any other information that may be helpful in establishing the reason for the abuse and the identity of the perpetrator(s).

If additional information is needed concerning reporting the Department of Health and Social Services suggests that you contact your local welfare department.

Governmental Responsibility

The Department of Health and Social Services furnished the following information.

The first responsibility of the county welfare department (or county children's board) is to see that the child is safe while a complete investigation is made. If the child is not hospitalized the question of whether he should be removed from his home, even temporarily, must be dealt with. In some cases such action may not be necessary; in others, arrangements will have to be made by the county welfare department to place the child in the temporary care of relatives or friends or in an emergency foster home.

Having received a report of an abused child the social worker may need to talk to the person making the report to aid in evaluating the child's parents or his home. The worker will meet with the parents, and will probably interview relatives, neighbors, law enforcement officers and others who may have

information that will help determine the true cause and nature of the child abuse.

The main concern will be to find out whether abuse is likely to be repeated if the child is returned to the home. The next step will be to develop a counseling plan aimed at stabilizing the family to prevent further abuse.

If removal of the child is necessary the county welfare department will petition the juvenile court for custody and will then place the child in a foster home or suitable child care institution. Meanwhile, the county welfare department will help the parents prepare for the time when their child may be safely returned to them.

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, alleged father and others to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

Reference: Sections 52.36 and 885.23, Wisconsin Statutes, 1965.

Consents for Treatment of a Minor

A minor is defined by the Wisconsin Statutes as a person who is under 21. Consents to treatment are necessary for minors as well as for those over 21. Consents may be oral as well as written, but unless a physician can produce disinterested witnesses with good memories, he will do better to have the consent in writing.

The proper person to consent to surgery or other treatment of a minor is either parent, or if neither parent is living, the minor's court appointed guardian. A physician is not legally protected by a consent signed by a relative of a minor, other than a parent, unless such relative has been appointed as such minor's legal guardian by a court.

There are two exceptions to the above general rule. First, in an *emergency*, a consent is *not* necessary if the parents or guardian cannot be located, and, in the judgment of the physician in charge and of consultants where consultation is practical, immediate treatment is necessary to save life or to prevent the deterioration or aggravation of the condition of the patient.

The legal reason for the above exception is that in an emergency the law *implies* the consent of the patient, or in the case of a minor, of his parent or guardian. BECAUSE THE LAW DOES NOT IMPLY CONSENT BEYOND THE TREATMENT ACTUALLY NECESSARY TO MEET AN EMERGENCY, THE PHYSICIAN MAY SAFELY TREAT ONLY THE EMERGENCY CONDITION ITSELF, AND NOTHING ELSE, WITHOUT ACTUAL CONSENT OF A PARENT OR GUARDIAN.

Second, an *emancipated* minor can give a consent for medical treatment, including surgery. A minor is emancipated (1) who is lawfully married, or (2) whose parents have divested themselves of their legal right of control over him. Typically a minor in the latter situation is one who is self-supporting. An unmarried minor attending school away from his home community is not emancipated by virtue of that fact alone.

A physician who has any doubt whether a minor is emancipated, should require the consent of a parent or the legal guardian before proceeding with non-emergency treatment.

Note: On the subject of consents generally, see 1958 *Blue Book* issue of this JOURNAL, Vol. 57, issue 1, pages 4–58.

Rehabilitation of the Epileptic in Wisconsin

JEAN P. DAVIS, M.D., Milwaukee, Wisconsin, and ADRIAN E. TOWNE, Madison, Wisconsin

VOCATIONAL REHABILITATION in Wisconsin has worked with the epileptic since the early 1930s. Success at first was negligible. Because seizure control was limited to those cases which would respond to phenobarbital, its sedative effect made employment difficult. Not until after 1938, when diphenylhydantoin sodium (Dilantin) provided the first nonsedative anticonvulsant, did it become feasible to think in terms of successful vocational rehabilitation of the epileptic. In 1942 the Rehabilitation Division undertook what was probably the nation's first study of vocational rehabilitation in epilepsy. Rehabilitation counselors felt that the controlled epileptic could contribute to wartime production, and the study showed that with proper placement the epileptic could make a definite contribution. Since World War II, vocational rehabilitation of the epileptic has been steadily increasing, to the extent that he now makes up about 5 per cent of all clients served.

In the mid-1950s, problems associated with epilepsy in Wisconsin came in for exhaustive study by the Rehabilitation Division. Findings of the survey constituted a widely circulated report in 1957. Analysis of the problem from the medical, educational, and employment aspects supported the thesis that the social problem in epilepsy today transcends the medical. Documented employer reluctance to hire the controlled epileptic stood out as the principal stumbling block in the return to normal life. This attitude was not confined to employers, the survey showed. In 1957 a number of Wisconsin public schools and colleges barred known epileptics.

Vocational rehabilitation services for the epileptic vary little from those provided other clients. Once eligibility is established, there must be medical and psychologic evaluations preparatory to establishment of a vocational objective. If something less than perfect seizure control has been achieved, Vocational Rehabilitation first refers the client to a specialist to work out the medical aspects of the problem. This may be at the University of Wisconsin Epilepsy Center in Madison, the Variety Club Epilepsy Center at Mt. Sinai Hospital in Milwaukee, or with other qualified specialists. In some cases severe emotional involvement may necessitate psychiatric consultation along with the seizure control efforts. Whenever possible, training will be undertaken concurrently with treatment. Training may range from instruction in basic work skills at a sheltered workshop to graduate study at the University. Our epileptic clients run the gamut of the IQ scale, so there can be no generalization as to one best vocational objective for them. We would steer all of them away from hazardous jobs.

In most cases the cost to epileptic clients for vocational rehabilitation will be negligible. No charge is made for counseling, guidance, and medical examinations. Tuition, books and training supplies are provided without cost. If financial need can be established on the basis of family income, the epileptic can also receive without cost the medical or psychiatric treatment needed to make him employable. Establishment of need is also necessary before we can pay transportation and maintenance costs during training or treatment. Most cases can establish need.

Eligibility for vocational rehabilitation services has been established by both state and federal statutes. It is based upon:

(1) The presence of a physical or mental handicap.
(2) The existence of a substantial handicap to employment.
(3) A reasonable expectation that through vocational rehabilitation services the handicapped person will again be able to work.
(4) The handicapped person must be of or near employable age.
(5) Residency in Wisconsin for one year is required, unless he was living in the state at the time of becoming handicapped.

The epileptic can refer himself for service to the Rehabilitation Division, but most will come on referral from educational institutions, hospitals, nurses, physicians, social workers, and related groups.

Surprisingly enough, comparatively few epileptics come to Vocational Rehabilitation on referral from physicians. This is unfortunate, because a closer relationship should exist between the medical profession and Vocational Rehabilitation, not just in the case of epilepsy but with all handicaps.

Removal of impairments is paramount in the rehabilitation process, whether by prosthetic devices, corrective surgery, speech therapy, or by other means. Such costs are underwritten by the Division

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Approved by the Division on Nervous and Mental Diseases of the State Medical Society's Commission on State Departments, Oct. 9, 1966.

Doctor Davis is a member of the Division.

Mr. Towne is administrator of the Division of Vocational Rehabilitation, State of Wisconsin.

of Vocational Rehabilitation once financial need has been established. In epilepsy, Vocational Rehabilitation stands ready to meet the expenses of seizure control where financial hardship exists. This is particularly important for those with intractable seizures. When patients do not respond to standard treatment methods, the physician should contact Vocational Rehabilitation to determine his patient's eligibility for VR services. This could lead to a specialist's care at Madison, Milwaukee, or elsewhere, hopefully resulting in seizure control which otherwise would remain unattainable.

If a physician has already achieved seizure control, he should then refer his patient to the Division of Vocational Rehabilitation for job preparation. Removal of the medical barrier is only one step. As long as the employment barrier remains, the epileptic's rehabilitation has just begun. Vocational Rehabilitation is geared to this problem, providing without cost the counseling, evaluation, training, and job placement services so necessary in the restoration of the epileptic to a normal life.

Following is a listing of Vocational Rehabilitation offices:

District I:

District Office	Local Office
117½ Monona Ave.	State Office Bldg.
Madison	Mormon Coulee Road
Telephone: 266–3655	La Crosse
R. R. VanDeventer,	Telephone: 784–0474
District Supervisor	J. Purcell, Acting
	Rehabilitation Supervisor

Mendota State Hospital
301 Troy Drive
Madison
Telephone: 244–2411
P. W. Rasmussen,
Rehabilitation Counselor

District II:

District Office	Milwaukee County Hospital
819 North 6th Street	9035 Watertown Plank Road
Milwaukee	Milwaukee
Telephone: 224–4677	Telephone: 258–2040
W. R. Newberry,	K. F. Krumnow,
District Supervisor	Rehabilitation Supervisor

District III:

District Office	Local Office
100 North Jefferson St.	200 Franklin Street
Green Bay	Wausau
Telephone: 432–8691	Telephone: 845–9261
Roger Siegworth,	R. C. Huser,
District Supervisor	Rehabilitation Supervisor

District IV:

District Office	Local Office
718 West Clairemont Ave.	917 Tower Avenue
Eau Claire	Superior
Telephone: 834–5051	Telephone: 392–8171
L. E. Opheim,	L. R. Forslund,
District Supervisor	Rehabilitation Supervisor

District V:

District Office	Local Office
312 Seventh Street	701 N. Barstow Street
Racine	Waukesha
Telephone: 632–4477	Telephone: 542–9414
E. C. Wilber,	G. Chrisien,
District Supervisor	Rehabilitation Supervisor

District VI:

District Office	Local Office
20 Forest Avenue	424 Washington Ave.
Fond du Lac	Oshkosh
Telephone: 921–5883	Telephone: 231–5220
J. A. Mather,	P. Monzel, Acting
District Supervisor	Rehabilitation Supervisor

Winnebago State Hospital
Winnebago
Sylvester Verbeten, Lynn Ehlenbeldt,
Rehabilitation Counselors

Wood County Project:

Court House	also office at
Wisconsin Rapids	116 West Second Street
Telephone: 424–1100	Marshfield
J. H. Roemer,	Telephone: 384–4310
Project Supervisor	

EDITORS' NOTE: As a part of the rehabilitation of epileptic patients, physicians should be aware of the possibility for the epileptic to obtain a temporary driver's license. The basics of the law establishing such temporary licensing are set forth below.

DRIVERS' LICENSES FOR EPILEPTICS

A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

(1) He submits with his application a certificate from a licensed physician recommending that a temporary driver's license be issued, and
(2) He is otherwise qualified to obtain a license.

The certificate is a form prepared by the Motor Vehicle Department and is designed to elicit medical information necessary to determine whether permitting the epileptic to drive would be a hazard to public safety.

To retain his license the epileptic must present a new certificate every six months.

The issuance of a temporary license is discretionary with the Motor Vehicle Department. A denial may be reviewed, however, by a special board.

Reference: Section 343.09, Wisconsin Statutes, 1965.

When a Lawyer Asks You for a Report

By WINFIELD S. MILLER II, LL.B., Oradell, New Jersey

"THE PHYSICIAN UPON proper authorization should promptly furnish the attorney with a complete medical report and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle his claim or suit, delay the trial of a case or cause additional expense or loss of important testimony."

So declares the interprofessional code of the A.M.A. and the American Bar Association. They jointly adopted it back in 1958.[1] Yet the problems of belated or inadequate medical reports that the code sought to end are still with us. Overlong time lags between the occurrence of accidents and the presentation of claims are still causing the loss of witnesses and evidence; incomplete and ambiguous medical reports are still doing disservice to patients, attorneys and justice.

It's not as if doctors were being asked to prepare reports for nothing. The interprofessional code spells out the fact that the physician "is entitled to reasonable compensation for time spent in . . . preparation of medical reports." Your patient knows you're busy and so does his attorney. But they need your help in personal injury litigation and are quite willing to pay for it. It's up to you to decide what you think is a fair fee in a given case, figuring it on the basis of time spent. However, it's a rare attorney who won't pay more for a prompt and proper report than for a slow and inadequate one.

Some attorneys point out that the inadequate jobs are usually the slowest to reach them. I suspect that one reason some doctors dawdle is that they're uncertain of how to compose a proper report. They're unsure of what to include and what to leave out. So it may be helpful to give a rundown on what the report should contain. Judging from my own knowledge and the experience of medicolegal colleagues, I'd say that the report designed to earn an acceptable fee should be handled along these lines:

1. The report should avoid going into detail about the accident. Naturally, the doctor should, if possible, give the date, time and place of the accident. He also should tell who gave the first aid, if any, and just what it was.

Unless the doctor actually witnessed the accident, however, there's a good chance he'll be wrong on some detail if he goes into a report of the accident itself. Any error can cast doubt on his competence and accuracy and may even cause the plaintiff to lose his case unjustly. At the least, a report on the accident can result in wasted time for all concerned in setting the record straight.

For example, one surgeon turned in a long report that looked fine—until the attorney spotted a glaring mistake. The doctor had stated that the lumber company employe in the case had been injured in a highway auto crash. In reality, the mishap had occurred in a storage shed in the lumberyard when the man was run over by a loading machine. Under the company's insurance policy, he was entitled to compensation. But because the policy excluded automobile injuries, the insurer would have denied liability if the doctor's error had been allowed to stand. Fortunately, it wasn't, but the surgeon and the attorney wasted valuable time fixing it.

Says Dr. Don Harper Mills, an M.D. and LL.B. who is associate clinical professor of forensic medicine and pathology at the University of Southern California: "If the doctor is the treating physician, his recitation of historical facts should be limited to those that were necessary for his diagnosis and treatment. Any facts of which he hasn't first-hand knowledge should always be prefaced by attributions such as 'the patient states' or 'the emergency room records disclose.' "

2. The report should give the date the doctor first examined the patient and should explain any delay between accident and examination. While on vacation in Vermont, a woman was knocked down by a bicyclist. Though bruised and shaken up, she seemed to have no serious injury. The next morning she awoke in much pain. Her husband urged her to see a local doctor, but she insisted on being examined by her own physician. They returned home to Rhode Island and found that their family doctor was away for the weekend. The woman's pain had subsided, so she decided to wait. When she finally saw her doctor, he decided to send her to the hospital, where she spent the next two weeks in traction. But he couldn't honestly say that the delay in getting treatment had worsened her condition.

In his medical report to the attorney some weeks later, the doctor stated, "I first examined the patient for this condition in my office on July 14, 1964."

Mr. Miller is Associate Editor, MEDICAL ECONOMICS.

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The accident had occurred on July 9. The report said nothing about the delay. But the insurance company's representative did. He successfully implied that the patient would have had far less pain and suffering if she'd been treated immediately. Her compensation was accordingly less than it should have been.

Most medicolegal experts hold that an adequate report should—if medically practical—state the circumstances of any such delay and the doctor's opinion as to how it may have affected the patient's condition. But some experts feel there should be no more than a well-attributed mention of what caused the delay—if that. "I don't usually advise doctors to go into explanations of why delays occurred," says Dr. Mills. "This is an embellishment that could lead to trouble. Let the attorney and his client fill in any such defect in the report, if necessary."

3. The report should give a complete description of the patient's symptoms and complaints when first examined. An injured patient's appearance may seem unimportant medically, but it could well affect his legal chances. If he was bleeding from lacerations, obviously this should be stated in the report. And, less obviously, if he was pale and cold, this should be mentioned. So should his complaints. If he said he felt faint and had back pain and a throbbing headache, this ought to go into the report.

Says attorney Mead Bailey of Sioux Falls, S. D.: "To make certain no complaints are overlooked, the doctor should carefully interrogate the patient. Naturally, the doctor has a good idea of what the complaints would be for any type of injury. Evidence that a patient did *not* have certain complaints can help to pinpoint and prove what the nature of injury actually was."

4. The report should describe all treatment and medication given. Not long ago, a doctor prescribed medication to relieve muscle spasm for several days after a woman's accident. When the pain continued after the pills were used up, he suggested she take aspirin daily. She did so for some weeks. Yet the doctor mentioned only the prescription pills in his report. Why should he also have included the aspirin? Because any treatment or medication, no matter how routine it may be to the doctor, could help determine the amount of the client's financial recovery for pain and suffering.

5. The report should mention continuing defects, disabilities or scarring. It should, for example, describe the size, location and extent of a scar caused by the accident. If the doctor has recommended plastic surgery, he should certainly say so. If he fails to report it, the attorney may not be able to include the cost of future surgery in the settlement figure.

If the physician thinks the patient is still suffering as a result of the accident, he should estimate in the report how long this will continue. He should estimate the cost of any medical care he thinks the patient may have to undergo.

Estimating how long the patient may continue to suffer the effects of the accident is especially important if there's a possibility of permanent injury. This can be vital in a case involving a minor. Once the court has approved a proposed settlement, no further damages may be sought for the minor, even though his injuries may prove to be more serious than at first reported. Of course, if it's too early for a prognosis, the doctor shouldn't guess. It's better to report that he's withholding his prognosis, pending future examinations.

So much for the elements that a medical report ought to contain. Now, how about its length? That depends entirely on the medical situation and how much there is to cover. The attorney needs a *complete* report, and the doctor may greatly increase the chances of an out-of-court settlement by doing a thorough job. An incomplete, vague report can lead to argument—and often to a trial. Thus, the time a physician spends on doing a finished job may save him a trip to court.

The doctor shouldn't hesitate to ask the plaintiff's attorney for help, if he needs it. And, if the doctor is pressed for time, he should request that the attorney come to his office for any necessary conferences.

Finally, the report should be submitted in triplicate and with a statement of the doctor's total fee. The amount, as I've suggested, should reflect how much time you and your aides have spent in preparing it and should include charges for any conferences required. Writing in MEDICAL ECONOMICS not long ago, Dr. Edgar Rosen, an Oakland, Calif., internist with a special interest in medical reports, made this comment: "One fee can't be assigned to all kinds of medical reports, any more than we can have one standard fee for all kinds of operations."

. . .

In any event, most doctors would agree with Jack H. Olender, a Washington, D. C., attorney specializing in personal injury cases, when he says, "It seems to me that a doctor's duty to try to heal and rehabilitate his injured patient includes the preparation, when requested, of a clear and full report that will be helpful to the patient in obtaining whatever compensation he's entitled to."

EDITOR'S NOTE:

1. Also consistent with interprofessional code between the State Medical Society of Wisconsin and the Wisconsin Bar Association adopted August 1955.

* * *

SMALLPOX IS A disfiguring as well as a highly communicable disease. It is prevalent in many areas of South America, Asia, and smallpox cases are still being reported in parts of Europe. The State Division of Health urges people in Wisconsin to be vaccinated against smallpox because of the influx of foreign students, international shipping by way of the St. Lawrence Seaway, and visitors from overseas.

Are You Risking an Abandonment Charge?

The doctor shortage and the mechanization of medicine are increasing the risks, says this attorney, who describes the dangers of telephone diagnosis and other traps

By NEIL L. CHAYET, Esq., Boston, Massachusetts

IT'S FAIRLY COMMON practice for a busy doctor to postpone seeing a patient. But it can also be a dangerous practice. For if the doctor's patient load is so heavy that he must neglect some of his patients—and a patient's condition worsens as a result of that neglect—he may be open to a charge of abandonment.

Abandonment suits still aren't everyday affairs, but they show signs of increasing. The probable reasons aren't far to seek: (1) the shortage of doctors, tempting physicians to take on more patients than they can handle; (2) "the mechanization of medicine"—meaning the increasingly impersonal doctor-patient relationship resulting from specialization and the related movement of medicine toward team care in highly mechanized hospitals.

On the whole, patients haven't realized how much the nature of medical practice has changed. They still expect their doctor to come running at the ring of a telephone. If he won't and hasn't warned them that he won't make house calls they may well feel abandoned—and make their next phone call to a lawyer.

Just what is the medicolegal meaning of abandonment? Laws vary from state to state and interpretations from court to court, but in general it means a physician's termination of a doctor-patient relationship without the patient's consent and without giving him adequate notice and opportunity to find another physician. Such a relationship is established when a doctor accepts a person as a patient. But in law, even simple-sounding words usually aren't as simple as they sound. Many abandonment cases have hinged on whether the doctor had indeed "accepted" the person as a patient and if so under what conditions or limitations. For some legal interpretations of the terms "doctor-patient relationship" and "accept" and "terminate," let's take a look at some specific situations and cases:

When a stranger phones you for emergency treatment. "I've got these terrible stomach pains," he tells you. "Could you come right away?" No statute compels you to accept any would-be patient, and you're on safe legal ground if you refer him to another physician or to the nearest emergency room. But there's one condition: Don't attempt to diagnose his illness or recommend treatment. If you do, a court may rule that you thereby accepted the stranger as a patient and so assumed the responsibility for his treatment.

New York had a case in point not long ago. A man awoke with severe chest pains and walked to the emergency room of a hospital three blocks away. He mentioned that he was a member of a group health plan. The nurse told him the hospital had no connection with the plan and put him in touch with one of the plan's doctors. Over the phone, the man described his pains and medical history to the doctor, who allegedly told him to return home and see his regular physician in the morning. The sick man obediently went home—and died. A suit against the doctor and the hospital was dismissed, but an appellate court ordered a new trial. Had the suit not been dismissed, the court ruled, a jury could have concluded that the doctor "undertook to diagnose the ailments of the deceased" and that the jurors thereupon "could have decided whether he had abandoned the patient." Eventually both doctor and hospital agreed to a settlement.

When a former patient demands to see you immediately. Is there a doctor-patient relationship when a patient whom you treated for a broken leg five years ago and haven't seen since asks to see you at once? The essential question here is whether the original relationship was terminated. This in turn depends on the nature of the illness. In the case of a broken leg, a court would probably hold that termination had occurred after complete recovery or, more specifically, one year after the doctor's final checkup and the payment of the bill. Thus you would have as much right to refuse to see this former patient as you would have to turn away a stranger.

When you want to terminate a relationship. In the case of a disease such as cancer, where the cure may not be final, either doctor or patient would have to end the relationship formally, usually with a letter of termination. Such a letter from a doctor should always advise the patient whether he needs further treatment and allow him enough time to arrange for it. Not long ago, the Florida Su-

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preme Court upheld a $65,000 verdict against a doctor who had discharged a patient suffering from a cancer that later enveloped his entire lower lip and chin. The doctor had neither recommended nor arranged for further treatment.

Formal termination isn't necessary with most of your patients; as in the case of the broken leg, termination is implied by the conclusion of the illness. Be sure, however, to terminate your relationship *officially* with patients who won't pay their bills. When a patient doesn't pay, it usually means he doesn't have the money or is dissatisfied with you. Either situation could motivate a suit. It has been argued that a letter of termination in itself may precipitate a law suit. It may—but it's riskier to do nothing and thereby invite an eventual charge of abandonment.

When a regular patient demands priority. Suppose a patient comes into your office and asks to see you at once, ahead of others waiting for you. You're on safe legal ground if you refuse to treat him ahead of other patients—unless he's come to consult you because of a genuine emergency. It's a physician's right to regulate his practice as he sees fit.

The question of what constitutes an emergency is also left to the doctor's medical judgment. But your judgment may have to survive a court test. Recently a Tennessee doctor and his nurse had to pay $25,000 for failing to respond in an emergency, even though it wasn't proved that their failure caused the patient's death. The mother of a 22-month-old boy, who was being treated for a tonsil and throat infection, had brought him to the doctor's office when his condition worsened. The nurse notified the doctor, who was at lunch, and then went to lunch herself. While both were out of the office, the child died after profuse vomiting.

When the mother sued both doctor and nurse for abandonment, the doctor and his expert witnesses testified that the child had died of a sudden viral infection. An appeals court affirmed that the jury could disregard such testimony and find that the child might have died of aspiration of its own vomit. In such a case, the court held, the child might not have died if he had received immediate treatment from either doctor or nurse. As this case makes clear, a doctor's momentary neglect may be enough to constitute abandonment.

When absence makes you unavailable to the patient. The key concept here is not the fact of leaving the patient, but leaving him without providing for his care in your absence. A few years ago, the Supreme Court of Oregon affirmed a judgment against a doctor who had neglected to make such provision. The suit was brought against him by a woman whom he had treated for a broken arm. Up to the day the doctor left for a vacation in Mexico, the woman complained that the cast on her arm was too tight, but he thought it unnecessary to split the cast or remove it. Nor did he entrust her to another doctor in his absence. When he returned and removed the cast, plaster and gauze were found imbedded in the flesh inside the elbow joint, according to one woman's testimony. Permanently crippled, the patient was awarded damages of $17,500.

The doctor planning a vacation or other trip must give his ailing patients enough advance notice of his impending absence to let them arrange for other medical help. How much notice depends on the illness. Two days would probably be enough for a patient with a broken arm, while 30 days might be in order for a patient requiring specialized treatment. Advance notice was at issue recently in Maine, where a doctor was granted a new trial after a jury verdict against him. Although the doctor had arranged for a competent substitute, he had failed to tell one of his pregnant patients that he was going on a two-day fishing trip.

During his absence, the woman's baby was delivered by the substitute. Later the woman sued her doctor charging that (1) she had suffered needlessly because the substitute failed to administer the anesthetic she wanted and (2) she had been denied the choice of another physician because her doctor hadn't warned her that he would be unavailable. The state Supreme Court took away her jury award on the ground that she had failed to prove she would have suffered less if her own doctor had been present. However the court confirmed the right of such a patient to receive plenty of advance notice concerning the need for a possible substitute obstetrician.

When a substitute physician errs. Are you responsible for your substitute's errors or derelections? Only if your patient can prove that you failed to exercise "due care" in choosing the substitute. A substitute may also be held liable for abandonment. That happened to a doctor who agreed with the surgeon, reversing a lower court decision and ordering a new trial. The suit was finally settled out of court.

The cases mentioned so far show patients seeking judgments for physical harm. But they may also try to collect damages for mental anguish. Unless accompanied by physical injury, however, mental anguish (as distinguished from mental illness) isn't usually actionable. Some courts, however, have ruled otherwise.[1]

In one such instance, a man was "abandoned" while receiving X-ray therapy for a cancerous growth on his cheek. He had been placed on a table with sandbags on both sides of his head and the X-ray machine trained on his cheek. Then the doctor and technician apparently forgot about him—after also neglecting to tell him that the machine would shut itself off automatically. The man lay there for three and a half hours, afraid to move, afraid not to move. Finally he fell off the table. He wasn't hurt physically, but the court allowed him to recover for his hours of mental anguish.

The cases cited show that a potential for a charge of abandonment exists in many common

situations. Happily, that potential is rarely realized. The physician can protect himself further with these four basic safeguards:

1. If you must turn away a patient, do so on medical grounds. It's acceptable to refuse a patient immediate attention if you feel others have more urgent need of your services. It's not acceptable to neglect him merely because you have too many patients.

2. When you accept a patient, state plainly whatever limitations you intend to put upon your services.

3. If you want to drop a patient or if a patient is dissatisfied and abandons *you*, be sure to send him a letter of termination. Keep all such correspondence as part of your records.[2]

4. Whenever you're going to be unavailable, notify patients who are acutely ill, pregnant, convalescing, or suffering from chronic disorders. Give those patients the name, address and phone number of a substitute physician.[3]

EDITOR'S NOTES:

1. After earlier hesitating about compensating for emotional harm suffered without attendant physical injury, the Wisconsin Supreme Court again considered this question in 1963. It held in *Alsteen v. Gehl*, 21 Wis. (2d) 349, at page 358 that the correct statement of the standard for legal liability is as follows:

> "One who by extreme and outrageous conduct intentionally causes severe emotional distress to another is subject to liability for such emotional distress and for bodily harm resulting from it."

2. The Society attorneys advise that after a physician gives notice that he wishes to withdraw from a case he should remain and perform necessary services until a successor physician acceptable to the patient takes over. Otherwise the first physician runs the legal risk of an abandonment charge, even though he gave written notice of his intention to withdraw.

3. An additional source of potential legal liability is the premature discharge of a patient. The legal principle has been well phrased as follows in a recent text:

> "Premature discharge of the patient may also result in a charge of abandonment if it turns out that the patient required further care under the standards of good medical practice."

Quoted from *Doctor and Patient and the Law*, Stetler and Moritz, The C. V. Mosby Company, 1962, p. 324.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

Only licensed physicians and registered pharmacists may sell contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used. In no event may such article, drug or preparation be sold to any unmarried person.

Prohibited also is the advertising or public display of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of one hundred dollars to five hundred dollars ($100 to $500), or imprisonment in a county jail not to exceed six months, or both.

Reference: Section 151.15, Wisconsin Statutes, 1965.

LAW REQUIRES SILVER NITRATE TO PREVENT INFANT BLINDNESS

The state law requires, and the State Medical Society recommends, the continued use of silver nitrate for the prevention of ophthalmia neonatorum.

Physicians are warned to use only the 1% solutions of silver nitrate prepared by the State Board of Health and distributed free to each physician through local health officers. The law also requires the physician to use the solution as directed in the prepared instructions.

Some birth certificates filed with the State Board of Health reveal that Wisconsin physicians are utilizing penicillin as a substitute for silver nitrate. However, professional circles still debate the efficacy of substitutions for silver nitrate. The State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments believes there is not enough evidence to recommend the use of substitutes. The American Medical Association has expressed the same attitude.

The use of any substitute for silver nitrate in the prevention of ophthalmia neonatorum subjects a physician to a fine of $100. In addition, it may subject him to a suit for malpractice.

Reference: Section 146.01, Wisconsin Statutes, 1965.

The Expert Witness

By BENJAMIN J. CANTOR, B.E.E., LL.B.

Beyond the basic qualifications of knowledge and experience necessary to be an expert in his field, an expert witness must also have the ability to communicate clearly and objectively his skilled interpretation of technical evidence. Mr. Cantor suggests thirty rules, ranging from manners to mannerisms, that will aid the expert witness in doing so, and thereby aid the judge and the jury in reaching a fair and proper conclusion from the testimony.

AN EXPERT WITNESS is one who has acquired by study, practice and extensive experience a special skill and superior knowledge in the art and science of a particular field about which persons who have no special training are incapable of forming an accurate opinion or of deducing correct conclusions. Whether a witness is qualified as an expert is a preliminary question of fact for the trial court to determine. This decision will not generally be overturned unless it can be shown that there was an abuse of discretion on the part of the presiding judge.

The expert witness differs from the ordinary witness in that the former can state his opinions or conclusions based on ultimate fact, whereas the latter can testify only to things that he saw, heard, tasted, smelled or felt. The weight that a jury will give to the testimony of an expert witness depends upon the extent of his learning, skill, experience and the reasons he gives for his opinions and conclusions.

The following factors are important in spelling out an expert witness's qualifications: education, experience, articles published, lectures delivered, membership in professional societies and organizations, awards and recognition as an expert by others in the same field. Because the expert witness' opinion often concerns one of the important elements of the case, *e.g.*, damages or liability, it is very important that he be well qualified and of high moral character and integrity. It must be remembered that the credence given by the court and the jury to the testimony of an expert witness depends principally on his qualifications, his ability to withstand severe cross-examination and his capability in expressing himself so that the judge and jury will understand his testimony.

Before an expert is put on the witness stand, the attorney should have a conference with him to determine his qualifications and also to seek his advice on the framing of questions. The attorney and the expert witness must have a meeting of the minds as to their objectives. In order to be most effective, the expertness of the witness and the legal astuteness of the lawyer should be aimed at the same objective.

As a witness, the expert should speak up so that the jury, judge, stenographer, opposing counsel and all other parties in the case can hear him. His testimony and explanations should be clear enough so that all of the jurors can understand and grasp them. Technical terms should be defined and put into simple language for effectiveness. In testifying from an exhibit, the witness should refer to the exhibit number or some other identification. When indicating or pointing to an object in the exhibit, he should describe what he is referring to so that the court stenographer can make an accurate and complete record of his testimony, which becomes very important when the transcript of the testimony is used in a hearing on a motion for a new trial or an appeal to a higher tribunal.

Enough time should be taken in answering questions so that the witness can gather his thoughts and give an accurate and brief answer. (It's like the fellow who apologized for writing a long letter and said that if he had had time it would have been shorter.) If the questions are answered quickly on direct examination, and then there is a tendency to slow up on cross-examination, the jury will notice this and feel that the witness is hedging or is in trouble. If the witness is asked to give an opinion and he feels that he hasn't enough facts or enough time to form an intelligent expert opinion, then he should so inform the court. A jury is impressed with such frankness on the part of a witness. The expert, not expected to rely entirely on his memory, should always have adequate notes in his possession when called as a witness so that he can testify as to all of the details. He should keep in mind that his role is to aid the court and the jury in understanding the technical evidence so that they can make a proper evaluation of the facts.

Some other suggestions which can be offered as an aid to being a good witness are:

1. Walk to the witness stand with even steps.
2. When taking the oath, hold your right arm up high with fingers straight and look at the officer administering the oath.

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3. When the officer finishes the oath, ". . . so help you God", you say "I do" in a loud voice so that all in the courtroom can hear. Do not act timid.

4. Think before you speak.

5. When one of the lawyers calls "Objection" or if the court interrupts, stop your answer immediately and wait until the court gives its ruling.

6. Be fair and frank. Don't be too anxious to please or too eager to fight.

7. If you make a mistake, or a slight contradiction, admit it and correct it. Don't tie yourself in knots trying to cover up some slip of speech or memory.

8. Keep your temper. Don't let anyone rile you into arguments over trivial points or even important ones. Be firm, but flexible.

9. If you can't answer "yes" or "no", say so. Modify your reply by "under certain circumstances . . .".

10. If you don't know or can't remember, say so. Those are legitimate answers to the most illegitimate questions.

11. Avoid mannerisms of speech. The habit of prefacing your replies with something like "I can truthfully say . . ." may cast unwarranted doubts on your whole testimony.

12. Don't get caught by snares like this: "Did you ever discuss this with anyone?" Of course you did, and if asked, name the people—the lawyer, the parties to the suit, etc.

13. If the lawyer asks you, "Are you as positive about this as the rest of your testimony?", STOP! Are you?

14. "Do you want this jury to understand . . . ?" Listen closely to that one. If you don't want the jury to understand it that way, make clear what you do want them to understand.

15. Never try to be a "smart" witness. If a lawyer is obviously giving you a chance for a wisecrack, avoid it like the plague. It's just the anesthetic before the knife—putting you in the "now-this-won't-hurt-a-bit" mood.

16. If the opposing attorney interrupts you before you have a chance to complete your answer, you should indicate this to the presiding judge.

17. Don't volunteer any information.

18. Express yourself well, using simple technical language that the jury, judge and attorneys can understand.

19. Be brief. Just answer the question and stop.

20. During the recess you should not carry on any conversation with other witnesses or parties to the controversy. You should stand aloof from everyone except the attorney who retains you to testify.

21. Don't chew gum.

22. Don't memorize any of your testimony.

23. Never nod your head to indicate "yes" or "no".

24. Speak up so that the judge, jury, counsel, stenographer and others can hear you.

25. Wait until the entire question is asked before answering.

26. On cross-examination, don't look at your attorney.

27. Keep your hands away from your mouth or face.

28. When addressing the court, use "Your Honor"; when addressing the attorneys, use their names.

29. At the conclusion of your testimony, ask if you may be excused; then leave the courtroom immediately.

30. Last, remember that the witness stand is not a comfortable place for one who is not telling "the truth, the whole truth and nothing but the truth".

An expert is entitled to a witness fee, the amount of which is subject to an arrangement between him and the attorney who calls him to testify. It is good practice to arrange for such a fee prior to testifying. If the expert is called on only to testify to facts of which he already has knowledge, he may be subpoenaed as a witness and paid the statutory fee, plus an allowance for travel. In this case he may refuse to give any "expert" opinion or testimony unless he is adequately compensated. An expert who is subpoenaed may not ordinarily be as cooperative and will not put as much effort into his testimony as one who has willingly agreed to appear as an expert witness. Thus, as a practical matter, the expert should be retained at a reasonable fee. If an expert must prepare himself before testifying by making certain tests or doing research, he is entitled to reasonable fees for that work. When an expert is called as a witness for the sole purpose of "proving" or verifying certain material, he is generally given a reasonable fee for his time.

It is wise, when called as a witness, to ask to be put "on call" so that there won't be time lost "hanging around" the courthouse. In any event, the witness shouldn't expect to be out of court in a hurry.

Some lawyers representing plaintiffs, especially in tort cases, will ask an expert to testify on a "contingent fee" basis—he won't be paid a witness fee if the plaintiff loses, but in the event that the plaintiff prevails, the expert will be paid. This puts the witness in the same position as the attorney who has a stake in the outcome of the case, and thus the witness gives up his proper role as a disinterested expert witness. Having a pecuniary interest in the case, the expert becomes an "interested" and biased party, and therefore his testimony will carry much less weight. It should be kept in mind that such a contingent fee arrangement is fundamentally against public policy and, therefore, invalid and unenforceable. The expert witness should be altogether objective and nonpartisan in presenting his opinions. He should keep in mind that he is being retained by the lawyer or party to the action and is not in their employ. He is an independent professional man.

Medical Staffing of Emergency Rooms; Legal and Ethical Considerations

By WAYNE E. STICHTER, Juris Doctor, Toledo, Ohio

THE TREMENDOUS increase in the past few years in the number of cases treated in the emergency rooms of hospitals, combined with the increasing difficulty in securing personnel, professional and non-professional, to staff the emergency department, has served to focus attention upon a number of questions with respect to the staffing and operations of the emergency department:

1. Legal questions affecting the hospital and its authority over the operations of the emergency room.
2. Legal and ethical questions affecting the medical profession generally and particularly those physicians who render emergency room care.
3. Practical questions affecting the hospital, the medical profession, and the public.

In order that we may understand the nature and extent of these problems and to discuss them intelligently, it is important, so it seems to me, to have an understanding of the facts that give rise to these problems—to ascertain the causes for the critical problems existing today in connection with the rendition of high quality medical care in the emergency department of a hospital.

Years ago the emergency room of a hospital was just what the name implies—a room in the hospital for the treatment of emergency cases, a room for providing immediate medical services for acute traumatic problems and life endangering situations. The public had not yet gotten into the habit of going to the emergency room for the treatment of a minor illness or injury; rather, the patient sent for or went to his own physician. Years ago, interns and residents in training in the hospital were generally adequate in number and sufficiently competent to handle these emergency cases—with the help, of course, of the attending physicians or members of the medical staff who might be summoned to the emergency room.

SITUATION TODAY

What is the situation today? Since World War II there has been an astronomical upsurge in the number of visits to the emergency room; indeed, surveys indicate that in the past five or six years there has been an increase—on the average—of 400 to 600 per cent in the number of cases treated in the emergency room. Concurrently with this astounding increase in the number of emergency room cases, there has been an actual decline in the number of interns and residents available for staffing of the emergency room.

We all know, of course, that in these same years there has been quite an increase in the number of traumatic injuries due to automobile accidents and perhaps other types of accidents (there has been an actual decline in industrial accidents). However, this increase in accidental injuries cannot possibly account for the great increase in the number of emergency room visits. The most plausible explanation for this large increase in emergency room visits lies in the fact that the hospital emergency room has gradually been converted into what one doctor has appropriately called "a neighborhood drop-in clinic." Recent statistical surveys reveal that of the total number of cases brought to the emergency room 50 to 80 per cent can be definitely characterized as non-emergency cases. These non-emergency cases, involving as they do minor illnesses or minor injuries, could just as well be taken care of in the physician's office. If this great volume of non-emergency cases could be diverted away from the emergency room, the present strain on the facilities and personnel of the emergency room would be greatly relieved, and the job of rendering prompt and adequate care to true emergency patients would be greatly facilitated.

WHY THE EMERGENCY ROOM?

Why does a patient with a minor illness or injury go to the hospital emergency room instead of to the doctor's office? Various reasons have been ascribed to this change in the pattern of cases brought to the emergency room. I shall mention only a few that have been advanced:

1. There are fewer general practitioners available for family care.
2. The patient may not have a family doctor.
3. The patient may not know what kind of a specialist to call to take care of his particular complaint.
4. Doctors are not always available at their offices whereas the hospital emergency room is always open.
5. The necessity of an appointment with the private physician.

Text of an address delivered by Mr. Stichter at the American Medical Association Legal Conference for State Medical Society representatives and executive secretaries, in Chicago on April 16, 1966.

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Reprinted with permission from the Ohio State Medical Journal, June 1966 issue, vol. 62, No. 6, pp. 600–604.

6. The automatic transportation of injury cases, however slight, to the emergency room (someone calls an ambulance and the ambulance driver automatically transports the patient to the hospital whether or not directed by the patient or someone in his behalf to do so).

7. A general belief that the equipment and facilities in the emergency room are more adequate and modern than those in the physician's office.

8. Physicians frequently encourage their own patients to go to the emergency room for treatment by them of the patient's minor illness or injury.

9. The major reason appears to be the public's general acceptance and seeming approval of the idea that hospital facilities—and particularly emergency room facilities—should be available for all kinds of illnesses and injuries—the idea that the hospital emergency room should be a sort of community medical center or "neighborhood drop-in clinic."

PROBLEMS IN SOME AREAS

Regardless of the validity of any of these reasons for this tremendous increase in the number of cases coming into the emergency room, the fact remains that the overwhelming demand for medical services in the hospital emergency room has created critical problems in some areas, such as:

1. The need for enlarged emergency room quarters.

2. The need for adequate modern equipment and facilities.

3. The need for adequate staffing of competent personnel, professional and non-professional, to handle emergency cases.

4. The need to reconvert the "community medical center" or "neighborhood drop-in clinic" into a true emergency room for the care and treatment of true emergency patients. Such reconversion will involve both the education of the public to the proper function and use of the emergency room, and the cooperative effort of hospital and medical personnel in the reference of non-emergency cases to the private practitioner, medical clinic or the out-patient department. This will also involve a complete separation of the emergency room department from the out-patient department.

All of these needs must be met. The public rightfully demands (and is entitled to) the rendition of high-quality medical care and the maintenance of emergency rooms which have the facilities needed for the prompt rendition of medical services by a staff of licensed physicians. Assuredly, the medical profession wants to see these rightful demands met. In meeting these demands, it is important to keep in mind two things: (1) the separate and distinct functions of the hospital and the medical practitioner, and (2) the fact that the proper and efficient operation of emergency room service requires close cooperation between the hospital and the medical profession in the performance of their separate functions. Each needs the other. The hospital cannot lawfully practice medicine. The medical profession cannot effectively practice medicine without the use of hospital facilities and non-professional personnel of the hospital.

SEPARATE FUNCTIONS AND RESPONSIBILITIES

The furnishing of the physical equipment and facilities of the emergency room, the furnishing of necessary non-professional personnel, and the general administration and operation of the emergency room, are the proper function and responsibility of the hospital.

On the other hand, the rendition of professional services in the emergency room is the exclusive right and responsibility of the medical profession; such professional services may legally be rendered only by duly qualified physicians directly or by hospital personnel under the direct supervision and control of the physicians. The hospital has no legal right to direct, control or supervise the rendition of any services which are of a professional character, regardless of whether such services are rendered by the hospital's non-professional employees, or by its salaried physicians, or by physicians under contract with the hospital; and any attempt by the hospital to direct, control or supervise such services would constitute, in my judgment, the unlawful practice of medicine. Furthermore, even though the hospital should not attempt to direct, control or supervise the rendition of professional services in the emergency room, the hospital would nevertheless be engaged in the unlawful practice of medicine if it receives the whole or any part of the fee charged for such professional services, or if the hospital otherwise derives any profit, financial gain or benefit from the rendition of such services.[1]

PRINCIPLES OF MEDICAL ETHICS

It should also be mentioned here that a physician who permits fee-splitting with the hospital, or who renders professional services (in the emergency room or elsewhere in the hospital for that matter) under an arrangement whereby the hospital derives some profit, financial gain or benefit, is guilty of a violation of the *Principles of Medical Ethics.*

In this connection, I call attention to Sections 6 and 7 of the *Principles of Medical Ethics* of the American Medical Association.

Section 6 reads:

"A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

Section 7 reads:

"In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under

his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient."

These sections have been interpreted by the Judicial Council of the AMA as forbidding the following:

1. Any interference by a hospital with the free and complete exercise of the physician's medical judgment or skill through any direction, control or supervision by a hospital over the physician's performance of medical services.
2. The receipt and retention by the hospital of the whole or any part of a fee paid for professional services rendered by a physician employed by the hospital on a salary basis or other contract basis, regardless of whether such payment is made to the physician and a part thereof delivered over to the hospital or whether the fee is paid to the hospital and the whole or a part thereof is retained by the hospital.

EXPLICIT UNDERSTANDING

How, then—it may be asked—can the demands of the medical public for adequate emergency room services be met without involving the hospital in the unlawful practice of medicine or involving the emergency room staff of physicians in a violation of the *Principles of Medical Ethics*? I submit that this can be accomplished by a clear, explicit understanding between the hospital and the emergency room physicians as to (1) the legal limitations on the functions and activities of the hospital, and (2) the ethical limitations that are imposed on all practicing physicians by the *Principles of Medical Ethics*, coupled with a willing obedience to these legal and ethical principles by the hospital and the emergency room physicians, respectively.

In this connection, it must be borne in mind that the unlawful practice of medicine by a hospital is usually accomplished through or by means of the unethical practice of medicine by the physician. It thus becomes readily apparent that if every physician will carefully refrain from entering into any arrangement with a hospital (1) which involves fee-splitting, or (2) which involves the obtaining by the hospital of some profit or other financial gain or benefit from the professional services of the physician, or (3) which subjects the physician to any direction, control or supervision by the hospital over his professional judgment—the practice of medicine by hospitals will be greatly reduced and, perhaps, eventually eliminated.

CONTRACTUAL ARRANGEMENTS

There are several forms of contractual arrangements for the staffing and operation of the emergency room which, if properly implemented and conscientiously adhered to, will not involve the hospital in the practice of medicine or expose the physician to a charge of violating the *Principles of Medical Ethics*. These may be summarized as follows:

Arrangement #1. This would provide for the rendition of services by use of bona fide interns and residents in AMA-Approved Emergency Room Training Programs, under the active guidance of the medical staffs. Under this plan, no charge would be made by the hospital for the professional services so rendered and no part of any fee that might be collected from the patient would be shared by the hospital.

Arrangement #2. Services would be rendered on a fee-for-service basis by several practicing physicians who would be approved by the medical staff with a minimum monthly compensation guaranteed by the hospital. As in Arrangement #1, no charge would be made, or fee collected or shared, by the hospital for any such professional services.

Arrangement #3. Services would be rendered by members of the medical staff either on a voluntary or mandatory assignment, and on a fee-for-service or gratuitous basis with billing, if any, direct by the physician for such professional services. Again, no charge would be made by the hospital for such services and there would be no splitting of fees as between the physician and hospital.

Arrangement #4. This provides for services to be rendered by several practicing physicians (employed by a medical partnership or a medical corporation) who would be approved by the medical staff. The billing and remuneration for such professional services would be the prerogative and responsibility of the medical partnership or corporation and the employed physicians. In no event would any charge be made, or fee collected or shared, by the hospital for any such professional services.

There is another form of contractual arrangement which might pass muster but which I think less desirable than the four forms of arrangements I have just mentioned. We shall call this "Arrangement #5." Under this Arrangement, services would be performed by one or more licensed physicians approved by the medical staff and employed by the hospital on a salary basis. Such services would be rendered without any charge being made by the hospital, or any fee collected or shared by the hospital, for such professional services. Further, there would not be included in the hospital's bill for hospital services any charge whatever for the professional services of the salaried physician. I consider this Arrangement #5 much less desirable because I think it is too much to expect that the hospital would pay a fair and reasonable salary without expecting and obtaining some financial benefit—by way of fee-splitting or otherwise—from the professional services of the salaried physician.

CONSIDERATION OF NEEDS

Each of these five arrangements or methods seems unobjectionable from the standpoint of legality and medical ethics. The selection of any particular method of staffing the emergency room will depend, I think, on the particular needs of the community and the particular conditions under which a group of physicians is willing to undertake the responsibility of staffing. Obviously, that method should be selected which promises to do the best job in the community (a) in rendering high quality medical care to emergency patients, and (b) in preserving and promoting the best possible relation between the profession and the hospital, between physician and physician, and between the medical profession and the public. Other things being equal, that method should be selected which affords the least opportunity—the least temptation—to the hospital and physician to indulge in practices which are unlawful from the standpoint of the hospital or unethical from the standpoint of the physician.

While each one of these several contractual arrangements, if conscientiously adhered to by the hospital and the emergency room physician, should prove effective in preventing the encroachment of hospitals upon the practice of medicine, there are other important factors that must be given serious consideration in the development of a successful hospital emergency room plan. In the first place, it is of the utmost importance, I think, that the hospital emergency room program have the full approval and support of the private practitioners in the community.

MEDICAL SOCIETY RESPONSIBILITY

We all know that it is the responsibility of the medical profession to see to it that adequate, high quality medical care is rendered at all times, in all places, to all patients. Consequently, the local medical society has, or should have, a decided interest as well as a professional duty with respect to the details of any plan for the staffing and operation of a hospital emergency room. The local society owes a duty to the public as well as to the local profession to ascertain whether the emergency room program will be implemented in such fashion as to insure the rendition of high quality emergency care. At the same time, it has the right, and it also owes the duty to the practicing physicians in the community, to insist that the activities of the emergency room staff be confined, as a general rule, to the treatment of true emergency cases to the end that there may be preserved complete confidence, respect, and harmony as between the members of the emergency room staff and private practitioners.

EVALUATING AN EMERGENCY ROOM PLAN

It is my belief that any contract, arrangement or plan for the staffing and operation of a hospital emergency room should be carefully analyzed and evaluated by the local society before the plan is finalized and put into effect. Any such plan might well be tested and evaluated on the basis of the answers to the following questions:

1. Is the plan such as to give assurance of the rendition of high quality medical care in true emergency cases on a round-the-clock basis?
2. Will the responsibility, control and direction of professional services in the emergency room be kept exclusively in the hands of the medical profession?
3. Will the group of physicians staffing the emergency room have the respect and confidence of the local society and of the profession generally, both with respect to the competence of the group and with respect to their ethics and integrity?
4. Does the plan provide that the physicians staffing the emergency room will limit their services and activities to true emergency cases and will render emergency services to a patient only if the patient's own physician is unknown or is not immediately available?
5. Will the treatment by the emergency room group of an emergency case be limited to such initial treatment as the emergency case requires?
6. Will the emergency room staff, as a matter of course, refer each emergency patient to his own physician for necessary follow-up care?
7. Will each non-emergency patient be referred to his own physician without treatment by the emergency room group except perhaps for necessary first aid? If the patient has no family physician, will the patient be afforded freedom of choice of physician—freedom to choose either a member of the emergency room group or some other physician? Will the emergency room group be circumspect regarding this matter so as to maintain the confidence, respect and esteem of their confreres in private practice?
8. Will the plan have the approval and cooperation of the local medical society and the medical profession generally?

It is obvious, I think, that the ideal emergency room plan will provide affirmative answers to each of these questions.

INTEREST OF THE PUBLIC

In the final analysis, the best interests of the public will be served, the best interests of the hospital will be served, and the best interests of the medical profession will be served if the emergency room plan clearly delineates, in writing, the respective functions, rights, responsibilities and obligations of the hospital and the physician. Regardless of the particular method selected for the staffing and operation of the hospital emergency room, the contractual arrangement between the hospital and each emergency room physician should be such as

(a) will allow the physician to retain his professional integrity and independence;

(b) will leave unimpaired the physician's right to the free and complete exercise of his medical judgment;

(c) will recognize the physician's right to fix, collect and retain the entire amount of his fee for professional services rendered to patients in the emergency room—without any fee-splitting of any sort or the deriving by the hospital of any profit, financial gain or benefit, directly or indirectly, from the professional services rendered by the physician; and

(d) will preserve and promote the best of relations between the medical profession and the hospital, between the emergency room staff physicians and their confreres, and between the medical profession and the public.

EDITOR'S NOTE:

1. Society attorneys advise that the foregoing paragraph and those which follow it are consistent with the Wisconsin law and constitute an excellent summary of the law as well as of medical ethics on the question involved.

Those having a special interest in the fee splitting aspects of the question should refer to the *Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959*, approved by the Council of the State Medical Society of Wisconsin in November, 1960 and distributed to all members.

RECENT CHANGES IN SELF-EMPLOYED RETIREMENT PLANS

Beginning January 1, 1968 a self-employed person can set aside 10% of his annual earnings or $2,500.00, whichever is less, to a qualified retirement plan. He may deduct his entire contribution. Previously only 50% of the self-employed person's contribution could be deducted.

One of the requirements of a self-employed retirement plan is that the self-employed individual must make contributions for all full-time employees with three years' service. The Internal Revenue has ruled that full-time employees who have worked for three years for physicians who shared the employees (no partnership) are employees of *all* the physicians for purposes of a self-employed retirement plan. If one of the physicians set up a retirement plan, he would have to make contributions for *all* of the shared employees. Thus, the cost of a self-employed retirement plar might be extremely prohibitive to the physician who shares employees with other physicians.

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was founded in 1954 to permit physicians and friends of medicine an opportunity to sponsor projects affecting the health of Wisconsin citizens.

Among the many projects which are supported by this method is the Medical Student Loan Fund. Since the integration of the loan fund into the Foundation in 1955, the student loan aspects of the program have grown.

Every practicing physician recognizes the unquestionable need for timely aid to the kin of his profession who face unusual financial hardship. Personal hardship strikes at physicians and their families as well as others. Through the Foundation there is an opportunity for professional persons to assist their colleagues who suffer adversity.

The Scientific medicine activities of the Foundation include circuit teaching programs, speakers service for county medical societies, and the support of research in many fields in cooperation with other agencies.

The Foundation has not neglected the value of learning from the past and the Museum of Medical Progress and Stovall Hall of Health, reconstruction of the Fort Crawford Hospital in Prairie du Chien, have made many visitors aware of the role that medicine has and is playing in their lives.

The voluntary contributions recommended by the House of Delegates is being supplemented by many physicians and others who find in the Foundation an opportunity for special gifts. Gifts may take a number of forms such as cash, life insurance, securities, books, old medical instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary in their wills. Gifts may be unrestricted, permitting the Trustees to use the funds for any purpose for which the Foundation was created. They may also be restricted or earmarked for specific purposes of interest to the donor. In any event, all contributions to the Foundation are deductible for income tax purposes.

Physician and Hospital Records Retention and Inspection

IT IS AGREED that ownership of medical and hospital records rests, respectively, with the physician and the hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because physicians, hospital personnel, patients and others are not always clear as to their respective rights and obligations, and because there is uncertainty as to what constitutes a "medical record" or "hospital record", representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly undertaken an *Interpretation* on this subject which is reprinted in full beginning with page 45 hereof.

The *Interpretation* was approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association. It contains recommendations and suggestions regarding hospitals' and physicians' responsibilities under Section 269.57 (4), which was enacted as part of Chapter 301, Laws of Wisconsin, 1959.

Patient and hospital records today include not only the written history, diagnosis, treatment, prognosis and related summaries, but such additional items as: x-rays, laboratory reports and correspondence with other physicians relative to a particular patient and to a particular condition.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 21 who are mentally competent; (2) over 21 who are mentally ill; and (3) under 21.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not of legal considerations.
2. A patient of legal age has *3* years within which to sue *for personal injuries*. If a patient elects to sue on *a contract* rather than for alleged *negligence*, he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. We are unaware of any *legal* requirement for accommodating a former patient longer than the suggested 6 years, although there may be sound reasons for retaining them longer. No statute of limitation runs where fraud can be established.
3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 21 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 21 and mentally ill at the time of his treatment or hospitalization,

or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within a maximum of 8 years.

C. If the patient is a sane minor at the time of the treatment or hospitalization, he must sue for the alleged negligence by the time he reaches 22, unless his guardian did so before he became of age.

4. To the extent that patients' records are retained to assist in collection of accounts, such claims must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

If you receive a request for examination and copying of records, it may not state what specific records are needed. Your records for that patient may go back for 20 years or more.

Before complying with the request of a patient to examine and copy his records, it is suggested that the physician confer, if practical, with the patient or his representative to ascertain *why* he needs his records copied for such a long period of time. If by any chance the records contain material relating to conditions which would be embarrassing to him, or which might involve other members of his immediate family, he might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records for such a long period. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any of such parties.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member. Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Some physicians are requesting not only that the time periods to be copied from a medical record be specified but also that each particular illness be specified in the authorization from the patient.

A number of other precautions are indicated in the *Interpretation* of Chapter 301, Laws of 1959, which follows. The physician or anyone designated to handle this matter would do well to review the contents of the *Interpretation before* interviewing the patient or preparing such parts of the medical record as the physician concludes to furnish.

Needless to say, the physician should not proceed under any circumstances without a *written* authorization signed by the patient; and the physician should be satisfied that: (1) the signature is the patient's, (2) he is mentally competent to make the request, and (3) the information is not of the character which would be likely to cause him nervous or other damage. While it is true the patient has what looks like a rather direct and simple legal right, the fact also remains, as to any specific care and treatment furnished by the physician, that the latter has a continuing responsibility toward him for such care and treatment.

The 1963 Legislature authorized the personal representative or the beneficiary of a life insurance policy to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Letters Testamentary" or "Letters of Administration" which are issued by the County Court, Probate Branch. In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) that the person signing the authorization is the beneficiary under the policy. The duty to provide the physician is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized.

Since no wording appears in the statutes prescribing the form of authorization to inspect and copy a patient's record, model forms are not recommended. Sample forms are included in the *Interpretation* which follows but they should not be construed as more than suggested guides designed primarily to make clear the illness and period for which inspection and copying are sought.

An Interpretation of Chapter 301; Laws of 1959

Creating parts of Section 269.57 of the Statutes

(Prepared jointly by The State Medical Society of Wisconsin and the Wisconsin Hospital Association)

1. Upon being presented with an authorization form for the inspection of medical records, physicians and hospitals must assure themselves that the patient did *in fact* sign the authorization, and that he was of *legal age* and had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian, and the hospital or physician must take such precautions as are necessary to satisfy themselves that those signing are thereby authorized to effect the release of the records of the patient.

The hospital or physician must be assured that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any prudent or reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the hospital administrator, or his representative, or the physician, depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the mental capacity of the patient or as to the authenticity of his signature.

On being satisfied that the authorization presented is properly signed, as previously outlined, and that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the hospital, institution or physician to permit such person to inspect and copy "medical or hospital reports, photographs, records, papers and writings" concerning the care and treatment of such patient.

It is first necessary to determine what must be made available for inspection and/or copying. It is believed that under a strict interpretation of subsection (4) of the statute, the physician's records (office or hospital), and the hospital clinical record or chart should be presented. In the case of x-rays there seems to be some disagreement among legal authorities that they are part of the medical record as such or are technically photographs. It is advised that x-rays *not* be released unless by court order, and that they be inspected *only* under proper supervision (in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator; in the case of a physician's office, by the physician in charge, an associate, or the designee of either).

Administrators and physicians should be cautioned that the copies of the records should be made only under properly authorized supervision, and that the originals of the records cannot be taken out of their custody at any time *except* under court order.

To avoid substantial wasted administrative or professional time with the examination and copying

NOTE

Chapter 301, Laws of 1959 created subsections (3) and (4) of Section 269.57, Wisconsin Statutes. Changes have been made in 1961 and 1963. The subsections now read as follows:

"(3) No evidence obtained by an adverse party by a court-ordered physical examination or inspection under sub. (2) shall be admitted upon the trial or by reference or otherwise unless true copies of all reports, photographs, records, papers and writings made as a result of such examination or inspection and received by such adverse party have been delivered to the party claiming damages or his attorney not later than 15 days after the said reports, photographs, records, papers or writings from any such court-ordered physical examination are received by the said adverse party, provided that in an action for recovery of personal injuries, the party claiming damages shall in return deliver to the adverse party against whom the action is brought a true and correct copy of all reports of each physician who has examined or treated such person with respect to the injuries for which damages are claimed.

"(4) Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person signed by his personal representative or by the beneficiary of an insurance policy on his life, the physician, surgeon or other person having custody of any medical or hospital reports, photographs, records, papers and writings concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records. Any person having the custody of such records who refuses to comply with such authorization shall be liable to the person receiving such medical care and treatment for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs.

"(5) The provisions of sub. (4) shall not be applicable to state or county mental hospitals, or to state colony and training schools, or to community mental health clinics established pursuant to s. 51.36."

CONSENT TO EXAMINATION OF PHYSICIAN'S RECORDS

To Dr. _____

I hereby authorize and request you to furnish a copy of the medical records of _____

_____, covering the period from _____ 19____ to
(State name of patient or "myself")

_____ 19____ or to allow those records to be inspected or copied by____

_____. I hereby release you from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

CONSENT TO ACCESS TO HOSPITAL RECORDS

o _____, Hospital Administrator, _____ Hospital.

I hereby authorize you to furnish a copy of the hospital records of _____

_____, covering the period from_____ 19____ to
(State name of patient or "myself")

_____ 19____ or to allow those records to be inspected or copied by _____

_____. I hereby release _____ Hospital and you personally from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

of records relating to illnesses which do not fall within the inquiry of the patient, it is strongly urged that the administrator or physician request that the illness and the period of time both be specified in the written authorization, or be agreed to by the person presenting such consent.

2. One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional reponsibility of the attending physician and of those acting under him. The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her acts or observations made pursuant to special or standing orders, is one which relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute.

Consistent with the above conclusion, it is believed (1) the notes of the attending physician, consultants, and of a resident, plus (2) the patient's chart, are *all* that make up the official hospital record. X-rays have been treated earlier in recommendation 1 herein. Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, or are not licensed to practice medicine, and are not recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic records relating to the care or treatment of the patient.

There has been understandable apprehension on the part of some hospital administrators and physicians that the production for inspection or copying of nurses' notes, or of comments by interns, social workers, and others, could embarrass or damage the interests of the patient, the hospital, or the attending physician. It is emphatically recommended that medical staffs and hospital administrators embark on an immediate, intensive, and continuing program of education which has as its sole purpose the maintenance of patient records which are limited to physical findings, diagnosis, treatment, prognosis, and to acts or observations made in the course thereof, or made pursuant to standing or special orders. If medical staffs, nursing staffs, and personnel under training, will so limit what they write, whether as part of the official patient record, or as part of an educational record, such apprehensions will disappear.

Again, emphasis should be placed on the importance of *physically separating* writings relating to a patient into (1) those made by or under the authority of the attending physician, consultant, or resident, and (2) those made for educational, training, internal, or other collateral purposes. The two categories of writings should be *separated* when the patient is *discharged* from the hospital, since only the first of them relates to the "medical care or treatment" of the patient, and is the only type of record called for by the new statute, and the only type which the physician or hospital should present for inspection or copying.

3. If an authorized person demands more than the above, it should be *refused* and a court allowed to rule on the request. If hospital administrators, physicians, and interested members of the public cannot determine what is embraced in the phrase "medical or hospital reports" relating to the "care or treatment" of the patient, a judicial determination of this question may well become necessary and even desirable.

4. It is further believed that the authorization to inspect and to copy is *personal* to the patient, and for that reason *does not survive* his death. Thus an authorization signed by an executor, administrator or member of a deceased patient's family has no legal effect under subsection (4) of the statute.

5. The potential liability of a hospital for defamation, and the statutory liability of the physician for "wilful disclosure" of professional secrets, deserve brief comment. Both are under the primary duty of not permitting the operation of the statute to be broader than its wording.

Section 269.57 (4) does *not* in words or by implication, give a right to remove any records from the hospital, institution, or a physician's office, the records being the property of the hospital, institution or physician.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on in the presence of a custodian (hospital or physician), or the representative of either. The statute does not require a hospital, institution, or physician to copy any records at the request of a patient or his representative. If a request is made by a patient or his representative, and the request is granted, the hospital, institution, or physician making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

6. Few people, other than medically trained personnel, will know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may

in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

7. The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but "as soon as the convenience of an administrator, a record librarian, or a physician, *reasonably* permits," after taking into account the urgency of prior demands on their time and personnel, and whether advance notice had been given of the demand of the particular patient.

8. When there is any indication that legal proceedings may ensue, the hospital, institution or physician served with a proper demand to examine or copy a patient's records should promptly notify its insurance carrier of this fact, and also the general attorney of the hospital, institution or physician. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such demand be given by the person receiving same to the other interested parties.

Joint Commission Standards for Dentistry in Hospitals

THE JOINT COMMISSION on Accreditation of Hospitals encourages the development of dentistry in a hospital atmosphere. The Commissioners urge hospitals that do not yet have dental departments to work toward their establishment.

The Commission's Bulletin No. 36, for August, 1964, declares that the dental service of a hospital may either encompass the total practice of dentistry or be limited to a lesser area.

The Bulletin defines the total practice of dentistry as including ". . . the diagnosis, prevention and treatment of any injuries, diseases or deformities of the teeth, the jaws and those structures generally involved in trauma or infection of dental origin." Within this compass are oral diagnosis and operative (restorative) dentistry, oral surgery, oral pathology, orthodontics, pedodontics, periodontics and prosthodontics.

TWO TYPES OF DENTAL SERVICE

Alternative ways of establishing a dental service in a hospital are offered.

If the hospital is small or limits its dental service principally to a single specialty, the Commissioners suggest a section of that specialty within the surgery department co-equal with the other surgical specialties. The Commission's Bulletin No. 44, for April, 1967, proposes a Medical–Dental Staff for a situation of this kind rather than a Dental Staff separate from the Medical Staff.

If the hospital is large or is a teaching hospital, the Commissioners suggest that the various dental specialties be sections of a department of dentistry ". . . with full consultative and advisory relations with the department of surgery." In this case, the hospital bylaws would call for a Dental Staff separate from the Medical Staff.

PARTICIPATION BY THE PHYSICIAN

In all cases, the Commission's standards require that ". . . the organization of the department of dentistry shall be comparable to that of other services or departments."

The standards also require that dental patients in the hospital be given the same careful medical appraisal as those admitted to other services. A staff physician must be available and will be responsible for the medical aspects of the dental patient's care throughout his hospital stay.

BYLAWS

Bylaws for each hospital having a dental service should specifically cover the following matters:

1. They should set the same requirements for staff dentists as for staff physicians on general membership qualifications, and on terms and procedures of appointment;
2. They should require staff dentists to abide by the principles of ethics of the American Dental Association and also by the same general ethical and moral standards as govern staff physicians;
3. They should clearly state the hospital's policies on the admission and discharge of dental patients, in particular declaring whether or not a dentist with staff privileges may admit and discharge his cases on his own initiative;
4. They should establish the same general rules and regulations for staff dentists as for staff physicians, with the following additional rules proposed in the Commission's Bulletin No. 36:

   "(a) Patients admitted for dental services may be admitted by the dentist either to the department of dentistry or to an organized

clinical service which is the oral surgery or other specialty service as periodontics, pedodontics, etc. In either instance, however, they must also be assigned to an attending physician on the staff.

"(b) As in all surgical cases, an adequate medical survey by a member of the medical staff shall be required on each patient before surgery. Consultation with the medical staff shall be required when medical complications are present. A licensed physician must be responsible for the care of any medical problems that may be present or arise during hospitalization.

"(c) Complete records, both dental and medical, shall be required on each patient and shall be a part of the hospital records."

DUAL RESPONSIBILITY

Throughout, the Commissioners emphasize that the dental inpatient must be well cared for by both the dentist and the physician. Uniformity of procedure from hospital to hospital is unimportant provided that the procedures in each hospital assure the desired dual dental and medical care.

QUESTIONS AND ANSWERS

1. May a dentist admit and discharge his cases? Yes, if the hospital has approved this procedure.
2. Who writes the history and physical? Both—the dentist is responsible for his field and will write the dental history and physical and its implications on the patient's general health; the physician, the medical history and physical. An adequate medical survey by a member of the medical staff shall be required on each dental patient before surgery.
3. Who writes the progress notes and the summary? Both if necessary, though if the case is primarily dental, it is presumed the dentist will write the bulk of the chart, and vice versa if the case is primarily medical.
4. Can a dentist sign a death certificate? No, except in seven states, namely, Alaska, Florida, Kentucky, Louisiana, New Mexico, Tennessee and West Virginia.
5. Can a dentist prescribe narcotics? Yes, if he has a narcotics license.
6. May an intern or resident write the medical history and physical examination? Certainly.
7. Must a physician be 'scrubbed in' when a dental case is operated on? Usually no. This is a question of judgment depending upon the qualifications and training of the oral surgeon and the severity or complexity of the case.

From BULLETIN No. 36, for August, 1964, of the Joint Commission on Accreditation of Hospitals.

THE PHYSICIAN AND LEGAL MEDICINE

The *Journal* of the AMA for September 7, 1963, contained an article entitled, "YOUR Professional Liability, 131 Questions and Answers." The questions include many which physicians are likely to encounter in their daily practice.

The answers follow the general rule of law in some instances, or the only rule in the case of other questions as to which there is very little court authority. This procedure was necessary when writing for physicians of the entire country but gives no assurance that the Wisconsin court has followed or will follow such rule were the same question before it. There may thus be some differences between answers given in the AMA article and those which an attorney would give to a Wisconsin physician.

The last paragraph of the introduction of the AMA article is sufficiently important to merit repetition. It states:

> "The following questions and answers do not eliminate the need for legal advice. Rather they help the physician to determine when it is necessary to call upon his personal attorney for such advice."

The article has been reprinted in pamphlet form and is available upon request to the Law Division of the American Medical Association.

Problems of a Physician's Widow

FOLLOWING the loss of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow will be faced with many decisions involving the settlement of the business affairs relating to her late husband's practice. It is of extreme importance that she act upon the advice of an attorney. When practical it is recommended that the physician acquaint his wife with his legal and other advisors and some of his business affairs. This will provide an established working business relationship between the wife and the advisors for that eventuality when she is called upon to act. Some of the chief problem areas the widow will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow will also be presented with the problem of what to do with the physician's narcotics. The District Supervisor, Federal Bureau of Narcotics, Chicago, Illinois, approved the following procedure in a recent communication to the State Medical Society:

> "The deceased physician's Tax Stamp, unused government order forms and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused government order forms (Form 2513) should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wisconsin 53202. The narcotic drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the District Supervisor, Federal Bureau of Narcotics, 1836 U. S. Courthouse and Federal Office Building, Chicago, Illinois, 60604, after the drugs have been inventoried on Forms 142, copies of which can be obtained from the District Supervisor. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs. No remunerations will be made for the narcotics surrendered to the Bureau of Narcotics."

It is important that a widow, other members of the family and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his death may be obtained from the State Board of Pharmacy, State Office Building, Milwaukee.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should *not* be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow can expect that the deceased physician's patients will seek care elsewhere unless he had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In such event, it is wise to insist upon a written request from the patient and his new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should *not* be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow's legal and other advisors can best inform her how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. She should carefully follow her attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow or the heirs to enforce collection by suit within such period. She should also seek legal and accounting advice on how long to retain the financial records of her late husband. It is quite possible that his estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

The State Medical Society office is always available for consultation with a widow, her family or the estate attorney.

Legal Responsibilities of the Physician-Patient-Hospital Relationship

THREE SPECIFIC questions pertaining to the physician-patient-hospital relationship were recently submitted to the Society's legal counsel by the Commission on Hospital Relations and Medical Education for an opinion. The questions and excerpts from the opinion of legal counsel are presented below.

1. Is there a special legal responsibility of a physician to his hospitalized patient?

There are no Wisconsin statutes which directly cover or govern the question set out above. The only statutes on hospitals relate to construction, safety, standards of maternity departments, and in the case of the Fee Splitting Statute forbid a hospital to employ a physician or to engage in a fee splitting arrangement with him.

In general terms, the courts have held that a physician has a legal responsibility to his hospitalized patient to furnish that degree of professional skill which is the standard of the medical community, and to give such professional attention to the patient as the case requires. A physician is not legally excused for inattention to one patient on the grounds that he was occupied with the needs of others.

A physician has a continuing responsibility to his hospitalized patient at least to the point where the latter is well enough to be discharged, or sooner leaves without the physician's authorization. A physician may be charged with abandonment for neglecting a patient who needs his care, whether during or after hospitalization. Once a physician has agreed to care for a particular patient, he must continue to do so until the patient no longer needs his professional services, and he may be legally liable for neglect of the patient, or for ceasing to care for him until another physician has replaced him, unless he has been clearly discharged by the patient before the relieving physician actually takes over.

While a hospital nurse or technician may technically be in the employ of the hospital, a physician may incur legal liability for permitting a nurse or technician to carry out his treatment orders or assist him when he knows or has reasonable cause to know that such person is unsuitable for such duties by reason of inadequate training, experience, judgment or personality defect.

The essence of negligence is the absence of the degree of care owed by one person to another. Legal liability results when negligence causes physical injury or monetary damage to the object of such negligence. The principles of law involved are few, but their application depends upon the facts of the case, frequently as evaluated by expert testimony, and as found by a jury or court.

2. What is the joint legal responsibility of the physician and hospital to a hospitalized patient?

The courts increasingly tend to distinguish the *administrative* negligence of a hospital from the *professional* or *medical* negligence of a physician. The first is concerned largely with the furnishing of safe and adequate facilities, equipment, food and related services and the carrying out of such routines as bathing or other general care. The other is concerned with professional treatment or care by the physician, or the carrying out of the orders of a physician by a nursing staff, technicians or others. A hospital is liable in general for *administrative* negligence, and a physician for *professional* negligence on the part of himself or an agent, where injury results.

It is also possible that both hospital and physician *could* be liable for concurrent or related acts of negligence which united to cause damage to a patient, or where the negligent acts of the one aggravated the injuries caused by the other party.

Where joint negligence has occurred, the patient may elect to sue the hospital, the physician, or both. If the patient prevails in court against the two, he may enforce his judgment wholly against the hospital or the physician as he may prefer. If there was in fact joint liability of hospital and physician but the patient enforced his judgment against the latter, the physician may then look to the hospital for recovery for such portion of the damages he has paid as represents the hospital's share of the total liability established by the litigation.

As a general proposition the hospital and physician have *separate* legal responsibility to the patient. The former is concerned primarily with safe and adequate facilities and the exercise of a due standard of care in the selection and supervision of its staff. The physician is concerned with the professional care which he either renders or directs on behalf of the patient. While the decisions of various courts furnish numerous instances of suits in which hospital, physician and nurse were jointly sued, it is not uncommon for a court or jury to determine during the course of the trial that no liability exists against one or more of the parties

sued. In some cases only the hospital, or the physician or the nurse is found to have been liable in a particular situation. In other cases two of them may be found negligent. In still other cases the suit is dismissed as to all three.

While the functioning of the hospital as an institution and of its nurses and technical staffs with the medical staff call for a high degree of coordination, teamwork and close understanding, all for the benefit of the patient, such facts do *not* of themselves create a joint legal responsibility. Perhaps the best explanation is that while teamwork and cooperation are *practical necessities* they do not automatically create a *joint legal responsibility.* It is up to the patient who asserts negligence to declare whether the hospital, as an administrative institution or as an employer, is responsible for his injury and damage, or whether the physician or others acting under his direction were primarily responsible.

It is therefore neither necessary nor advisable to try to generalize a joint responsibility since it is seldom present in fact.

3. What is the extent of legally enforceable rights of a physician against a hospital in which he has staff privileges?

The legally enforceable rights of a physician against a hospital growing out of his staff privileges are relatively limited in character. Thus a staff physician cannot demand that certain managerial policies be adopted, for that is the function of the governing board and its administrator. He cannot demand that the hospital purchase certain equipment, but is entitled to observe that such equipment as it has is inadequate, poorly maintained or unsafe. The latter right grows out of his concern for patient interest and his professional competence to make the observations.

There are two areas worthy of comment in which a staff physician has legally enforceable rights. The first is exemplified in the so-called "inhospital staff specialties" such as radiology, pathology and physiatry. When the medical staff and the governing body of a hospital consider that it is in the public interest, it is lawful for practitioners in these specialties to contract with a hospital to provide consultation services for attending physicians. Such consultants must be members of or acceptable to the medical staff of such hospital. So long as a contract between such a specialist and a hospital relating to his practice is in accordance with the fee splitting statute and other applicable laws, it is enforceable by him against the hospital and by the hospital against him.

The second area of legally enforceable rights enjoyed by staff physicians are those which relate to staff privileges as such. The documents which govern staff privileges are typically bylaws, rules and regulations, the application of an individual physician for staff privileges and the official action on such application, first, by the medical staff, and then by the governing body of the hospital. A physician whose staff appointment is regular in every respect acquires legally enforceable rights once he becomes a member of the medical staff. Those rights depend upon and are limited by the provisions of the hospital bylaws, rules and regulations, and by any particular conditions attached to his appointment, such as limitations on surgical privileges.

It is the proper business of the individual and collective membership of a medical staff to see that the granting of staff privileges, their limitation, suspension and termination are spelled out clearly, adequately and fairly. This is a matter of proper concern to patients whom the physician may hospitalize, and of enlightened self-interest to physician and hospital as well.

There appears to be a trend generally in the courts of this country to recognize something akin to a property right in hospital staff privileges *once they are granted,* so long as they remain in force, and assuming that the physician is not guilty of acts of professional negligence or misconduct. This means that the trend of the courts is away from permitting summary suspension or termination of staff privileges without a fair hearing, except for grave cause which might endanger patients or create liability on the part of the hospital.

In my judgment increasing importance should be attached to "negotiations" between the medical staff and the governing body or administrator of a hospital. These can be conducted by the Chief of Staff of a very small hospital, or by the Executive Committee of the medical staff of a larger hospital, in areas in which patient welfare and safety are involved, or in which tensions or conflict may arise between hospital policy and medical policy to the detriment of patient welfare. The latter are not matters of contract right as such, but are akin to "collective bargaining", and become a matter of understanding at the point the hospital and the medical staff are in agreement. They might include such areas as the unwillingness of the governing body of the hospital to follow medical staff recommendations for granting or limiting staff privileges; failure to purchase desirable or needed equipment or to replace equipment in the interests of patient safety or welfare; inadequate selection of the nursing, technical and other staffs of the hospital, or insufficient supervision and continued training during the course of employment.

While we find no Wisconsin cases on the point, a physician undoubtedly could, as we earlier indicated, enforce a right of contribution against the hospital in a situation in which he had been held liable and a judgment enforced against him, although the liability was partially that of the hospital.

* * *

Many points have not been covered in this opinion because they did not seem closely enough related to the questions. Thus, there has been no discussion of the contractual relationship between patient and physician. Rather it has been assumed to exist for purposes of answering the questions. No questions

of adequacy of patient consent, either from the standpoint of physician or hospital, have been touched upon. It has been assumed also that hospital records were adequately maintained by the physician and by the non-medical staff under his direction, and that in other respects not specified the hospital and its employees were functioning properly and the physician was acting within the limits of the standard of professional care owed the patient.

MALPRACTICE DEFINED

MALPRACTICE . . . Section 147.22 of the Wisconsin Statutes, quoted below, is concerned with the legal consequences to those who "treat the sick" without or beyond the limits of a license or certificate of registration. One such consequence is full liability for the penalties of malpractice even where it is the result of ignorance rather than negligence or lack of skill. The wording covers failure to perform or attempt to perform as well as actual performance.

The statute has application to such persons as chiropractors, podiatrists, or optometrists when they exceed their respective limited licenses or certificates.

Section 147.22 reads as follows:

> "Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the afflicted without having a license or a certificate of registration authorizing him so to do, shall be liable to the penalties and liabilities for malpractice; and ignorance on his part shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners."

NARCOTICS

Annual Registration

You must register with and pay tax to the District Director for the Internal Revenue District in which you propose to engage in any activity involving the use of narcotic drugs. For Wisconsin, the correct address is District Director, Internal Revenue Service, Post Office Building, Room 296, Milwaukee, Wisconsin 53202.

Change of Residence

Do not fail to notify the District Director, Milwaukee, Wisconsin, of any change of address. Failure to notify him within 30 days will make you subject to the tax, penalty and interest.

In Case of Death

The District Supervisor, Bureau of Narcotics, Chicago, Illinois, whose jurisdiction encompasses the State of Wisconsin, has notified the State Medical Society that the following conforms with current Federal Regulations:

> "The deceased physician's Tax Stamp, unused government order forms and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused government order forms (Form 2513) should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wisconsin 53202. The narcotic drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the District Supervisor, Federal Bureau of Narcotics, 1836 U. S. Courthouse and Federal Office Building, Chicago, Illinois 60604, after the drugs have been inventoried on Forms 142, copies of which can be obtained from the District Supervisor. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs. No remunerations will be made for the narcotics surrendered to the Bureau of Narcotics."

Preprinted Prescription Blanks

The Treasury Department, Federal Bureau of Narcotics, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

Physicians' Guidelines for Delegation of Duties and Functions to Nurses

THE SOCIETY has been asked on a number of occasions whether a certain procedure could be performed by a nurse. Following are some guidelines for a physician to follow when he considers delegating some function, procedure or duty to a nurse.

Three general principles control delegation to nurses. They are:

1. A physician can lawfully delegate to nurses only those functions, procedures or duties which do not require the exercise of his professional judgment.
2. The nurse must have training and experience in the function, procedure or duty to be delegated by the physician.
3. All such functions, procedures or duties must be performed under the direction or supervision or upon the prescription of a physician.

The "practice of medicine" has been described as the primary professional responsibility of the physician for the total care of his patient. Under Wisconsin law a physician is granted an unlimited license. This is legislative recognition of his comprehensive training and his corresponding professional responsibility. Nurses are not granted such a license nor are they trained for such an overall responsibility. It should not be necessary to reiterate that a nurse cannot "practice medicine", or that a physician cannot, except in a genuine emergency, lawfully delegate the power to practice medicine to her wittingly or unwittingly. This is true even though the nurse is willing to perform a function that requires the exercise of the professional judgment of a physician.

The late Louis J. Regan, who was both a doctor of medicine and an attorney, speaking of industrial nursing, sums up the delegation question in the following words:

> "Authority to diagnose, treat, operate or prescribe cannot be delegated."
>
> LOUIS J. REGAN, *Doctor and Patient and the Law*, 3rd Ed., p. 484

Doctor Regan's text also contains the statement on page 483 that a nurse "should assume no responsibility for service outside the field of her professional training." A professional nurse's training is comprehensive in the field of nursing, but it does not encompass training for the practice of medicine. A nurse who is not trained in a procedure and does not have experience in it should not be allowed to perform it. Professional liability for her acts could attach to the physician who ordered a nurse to perform a procedure beyond her competence.

The training of nurses is divided into two levels. The longer and more comprehensive training leads to professional nursing and the lesser to practical nursing. These are separately defined in the Wisconsin Statutes. Section 149.10(1) of the Wisconsin Statutes defines "professional nursing", and Section 149.10(2) defines "practical nursing". These definitions are as follows:

> "149.10 Definitions. (1) Practice of Professional Nursing. The practice of professional nursing within the terms of this chapter means the performance for compensation of any act in the observation or care of the ill, injured or infirm, or for the maintenance of health or prevention of illness of others, which act requires substantial nursing skill, knowledge or training, or application of nursing principles based on biological, physical and social sciences, such as the supervision of a patient, the observation and recording of symptoms and reactions, the execution of procedures and techniques in the treatment of the sick *under the general or special supervision or direction of a physician*, the execution of general nursing procedures and techniques and the supervision and direction of trained practical nurses and less skilled assistants."
>
> "(2) Practice of Practical Nursing. The practice of practical nursing under this chapter means the performance for compensation of any simple acts in the care of convalescent, subacutely or chronically ill, injured or infirm persons, *or of any act or procedure in the care of the more acutely ill, injured or infirm under the specific direction of a nurse or physician.* A simple act is one which does not require any substantial nursing skill, knowledge or training, or the application of nursing principles based on biological, physical or social sciences, or the understanding of cause and effect in such acts and is one which is of a nature of those approved by the board for the curriculum of schools for trained practical nurses." (Italics supplied)

Note that in the definition of professional nursing a nurse can treat the sick only "under the general or special supervision or direction of a physician."

Similarly, attention should be given to the italicized wording in subsection (2), quoted above. It says, when read with the first part of the sentence, that "practical nursing" means *not only* simple acts in the care of convalescent and other specified persons, but also "*any act* or *procedure* in the care of the more acutely ill, injured or infirm under the *specific* direction of a [professional] nurse or physician."

The reasonable meaning of the above is that a practical nurse is not limited by statute to what

is described in the first part of subsection (2). A trained practical nurse may *also* perform any act or procedure in the care of the more acutely ill, injured or infirm, *provided* she does so under the specific direction of (a) a professional nurse, or (b) a physician.

Some common sense considerations need to be observed, however. First, neither a physician nor a professional nurse can *lawfully* delegate to a trained practical nurse an act or procedure which would be legally improper for the professional nurse. Second, the phrase "specific direction" reasonably means *in the presence* and under the *immediate supervision* of the physician or professional nurse. This provides the safeguards indicated by the more limited training, skill and experience of the practical nurse.

However, neither type of nurse is authorized by the statutes to diagnose, operate or prescribe. Even the professional nurse can treat the sick *only* under physician supervision or direction.

Supervision or direction of a professional nurse by a physician can take many forms. Physical presence of the physician is not necessarily required in all instances. Many things are done upon the prescription of the physician. In this sense the prescription of a physician means a written order of a physician. This can be either a prescription as used in its normal meaning or an order written in the hospital or other charts.

In the last analysis, the matter becomes one of common sense of the physician, supplemented and guided by his professional training and experience and, equally important, by medical ethics and tradition.

Abortion and the Wisconsin Law

THE WISCONSIN Criminal Code provides a fine up to $5,000.00 or imprisonment up to three years or both for the intentional destruction of the life of an unborn child. The law states that an "unborn child" means a human being from the time of conception until it is born alive. If the life destroyed is that of an "unborn quick child" or of the mother, the imprisonment may be as high as 15 years.

A therapeutic abortion is exempt from these penalties, but only when three specific conditions have been met:

1. The abortion must be performed by a physician.
2. At least two other physicians must advise that the abortion is, or appears to be, necessary to save the life of the mother. Therapeutic necessity must be based on danger to the mother's life, not simply on danger to her health. In an emergency the physician is permitted by statute to perform an abortion without the advice of two physicians, but he must be able to prove that the abortion was necessary to save the life of the mother.
3. The abortion must be performed in a licensed maternity hospital, except where emergency prevents.

If you are called upon to treat a woman who has had an attempted or completed abortion:

1. Insist on the presence of at least one other physician (not an associate) before treatment is given, or
2. When no other physician is available, insist on a written statement from the patient, in the presence of witnesses if possible, reciting the facts concerning the performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after the patient understands that the physician may use the statement in the event he later requires it for his own protection.

The above two steps are recognized by the Wisconsin Supreme Court as reasonable precautions before treating a woman who has had an attempted or completed abortion.

Abortion Deaths To Be Reported

Sometimes forgotten is the statutory requirement that all physicians must immediately report knowledge of any death following an abortion. The report must be made to the sheriff, police officer, or coroner of the county in which the death occurs.

Legal counsel for the Society believes the reporting requirement is intended to apply only to those situations in which the mother dies following an abortion and not to the destruction of a fetus. Pending clarification of this point by the legislature or the courts, the physician will do well to report *all* deaths associated with abortion.

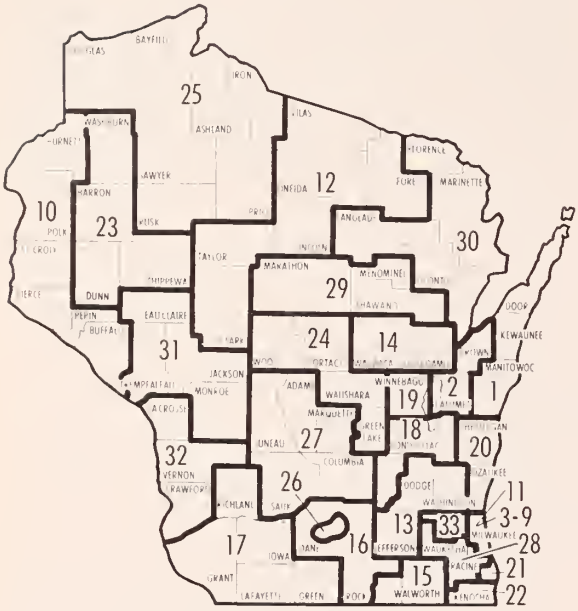
REFERENCES

1. Wisconsin Statutes, 1965, Section 940.04
2. Wisconsin Statutes, 1965, Section 966.20
3. *State v. Law* (1912) 150 Wis. 313

Wisconsin Legislature

DIRECTORY OF MEMBERS

Prepared by the Wisconsin Taxpayers Alliance, Madison, Wisconsin



SENATE DISTRICTS

ASSEMBLY DISTRICTS

TAX DEDUCTIBILITY OF HEALTH AND ACCIDENT INSURANCE

As a result of Public Law 89–87, one-half of medical care insurance premiums up to a maximum of $150.00 are fully deductible. Additional medical care premiums may be included with other medical expenses and are subject to the limited deduction of the excess of medical expenses over 3% of adjusted gross income up to the applicable maximum.

Public Law 89–87 also reversed the advantages the courts had given taxpayers by permitting total premiums of health and accident policies which provided indemnity for accidental loss of life, limb, sight or time, to be deductible medical expenses for federal income tax purposes.* Only that portion of such policies which is allocable to medical care is now deductible and *only* if the charge for medical care is separately stated in the policy or in a statement sent to the policyholder by the insurance company. In addition, the charge for medical care on a combination policy is eligible for a medical expense deduction only if not unreasonably large in relation to the total premium under the contract.

Finally, the liberalized medical expense deductions which were available to taxpayers over the age of 65 have been removed. All taxpayers, whatever their age, are now subject to the same general rules. Disabled taxpayers over 65 still are eligible for a higher maximum medical expense deduction.

The same rules as are set out above also apply for 1967 Wisconsin income tax purposes.

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* Thus, the tax benefits noted at page 59 of the January 1967 issue of the *Wisconsin Medical Journal* are no longer available.

State Officers

Governor—KNOWLES, WARREN P. (R), 251 W. 2nd St., New Richmond

Lt. Governor—OLSON, JACK B. (R), 925 Church St., Wisconsin Dells

Secy. of State—ZIMMERMAN, ROBERT C. (R), 2810 Arbor Drive, Madison

State Treasurer—SMITH, DENA A. (R), 1628 W. Wisconsin Ave., Milwaukee

Attorney General—LAFOLLETTE, BRONSON C. (D), 733 Lakewood Blvd., Madison

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PROXMIRE, WILLIAM (D), 4613 Buckeye Rd., Madison

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REPRESENTATIVES

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1. SCHADEBERG, HENRY C. (R), 333 Emerson St., Burlington
2. KASTENMEIER, ROBERT W. (D), 300 N. Water St., Watertown
3. THOMSON, VERNON W. (R), 578 E. Second St., Richland Center
4. ZABLOCKI, CLEMENT J. (D), 3245 W. Drury Lane, Milwaukee
5. REUSS, HENRY S. (D), 925 E. Wells St., Milwaukee
6. STEIGER, WILLIAM A. (R), 684 Oak St., Oshkosh
7. LAIRD, MELVIN R. (R), 313 E. Third St., Marshfield
8. BYRNES, JOHN W. (R), 406 N. Washington St., Green Bay
9. DAVIS, GLENN R. (R), 2300 Springdale Rd., New Berlin
10. O'KONSKI, ALVIN E. (R), Mercer

Members of the Wisconsin Senate

Dist.	Name (Party)	District (Counties)	Address
1.	°Meunier, Alex J. (R)	Door, Kewaunee, Manitowoc	45 S. 3rd Ave. Sturgeon Bay
2.	–Warren, Robert W. (R)	1st, 2nd assembly districts, Brown; Calumet	503 Northern Bldg. Green Bay
3.	°Kendziorski, Casimir (D)	11th, 12th, 14th assembly districts, Milwaukee	2025 S. 14th St., Milwaukee
4.	–Leonard, Jerris (R)	3rd, 18th, 25th assembly districts, Milwaukee	626 E. Wisconsin Ave., Milwaukee
5.	°Schuele, Wilfred (D)	2nd, 9th, 15th assembly districts, Milwaukee	3036 N. 84th St., Milwaukee
6.	–Schreiber, Martin J., Jr. (D)	1st, 5th, 7th assembly districts, Milwaukee	740 N. Plankinton Ave., Suite 510, Milwaukee
7.	°McParland, Leland S. (D)	17th, 19th, 24th assembly districts, Milwaukee	4757 S. Packard Ave., Cudahy
8.	–Busby, Allen J. (R)	20th, 21st, 22nd assembly districts, Milwaukee	1673 S. 53rd St., Milwaukee
9.	°Sussman, Norman (D)	4th, 6th, 13th assembly districts, Milwaukee	1621 W. Wisconsin Ave., Apt. 3, Milwaukee
10.	–Knowles, Robert P. (R)	Buffalo, Pepin, Pierce, Burnett, Polk, St. Croix	130 S. Main St., New Richmond
11.	Whittow, Wayne F. (D)	8th, 10th, 16th assembly districts, Milwaukee	4921 W. Washington Blvd., Milwaukee
12.	–Krueger, Clifford W. (R)	Clark, Forest, Oneida, Vilas, Lincoln, Taylor	122 N. State St., Merrill
13.	°Panzer, Frank E. (R)	1st assembly district, Dodge; Jefferson, Washington	Route 1, Brownsville
14.	–Lorge, Gerald D. (R)	Outagamie, Waupaca	Bear Creek
15.	Swan, James D. (R)	1st, 3rd assembly districts, Rock; Walworth	RR 2, Elkhorn
16.	–Thompson, Carl W. (D)	4th, 5th assembly districts, Dane; 2nd assembly district, Rock	P.O. Box 227 Stoughton
17.	°Roseleip, Gordon W. (R)	Grant, Green, Iowa, Lafayette, Richland	Box 167, Darlington
18.	–Hollander, Walter G. (R)	2nd assembly district, Dodge; Fond du Lac	Route 1, Rosendale
19.	°Draheim, William A. (R)	Winnebago	913 Hewitt St., Neenah
20.	–Keppler, Ernest C. (R)	Ozaukee, Sheboygan	719 New York Ave., Sheboygan
21.	°Dorman, Henry (D)	1st, 2nd assembly districts, Racine	212–5th St., Racine
22.	–Lourigan, Joseph (D)	Kenosha	3604 19th Ave., Kenosha
23.	°Rasmusen, Holger B. (R)	Barron, Chippewa, Dunn, Washburn	722 Franklin St., Spooner
24.	–Hansen, William C. (D)	Green Lake, Waushara, Portage, Wood	Route 4, Stevens Point
25.	Cirilli, Arthur A. (R)	Ashland, Bayfield, Douglas, Iron, Price, Rusk, Sawyer	909 E. 4th St., Superior
26.	–Risser, Fred A. (D)	1st, 2nd, 3rd assembly districts, Dane	15 W. Main St., Madison
27.	Terry, Walter E. (R)	Adams, Columbia, Juneau, Marquette, Sauk	Route 3, Baraboo
28.	–Benson, Taylor (D)	23rd assembly district, Milwaukee; 3rd assembly district, Racine; 4th assembly district, Waukesha	6729 Hwy. 38, Franksville
29.	Chilsen, Walter John (R)	Marathon, Menominee, Shawano	Rt. 5, Box 25, Wausau
30.	–LaFave, Reuben (R)	3rd assembly district, Brown; Florence, Marinette, Langlade, Oconto	Box 89A, Route 1, Oconto
31.	Johnson, Raymond C. (R)	Eau Claire, Jackson, Monroe, Trempealeau	221 N. 12th St., Eau Claire
32.	–Bice, Raymond C. (R)	Crawford, Vernon, La Crosse	2406 State St., La Crosse
33.	°Dempsey, Chester E. (R)	1st, 2nd, 3rd assembly districts, Waukesha	Route 1, Hartland

–Hold-over senator from 1965 legislature.

°Served in 1965 senate.

Senate terms for even-numbered districts expire on the second Wednesday of January 1969 and odd-numbered districts on the second Wednesday of January 1971.

Members of the Wisconsin Assembly

District (Counties)	Name (Party)	Address
Adams, Juneau and Marquette	Thompson, Tommy G. (R)	1407 Academy St., Elroy
Ashland, Bayfield and Iron	•Gehrmann, Bernard E. (R)	801 Prentice Ave., Ashland
Barron and Washburn	Van Hollen, John C. (R)	720 Lakeview Dr., Chetek
Bayfield (See Ashland)		
Brown, 1st	•Quinn, Jerome (R)	137 N. Oakland Ave., Green Bay
Brown, 2nd	•Kafka, Lawrence J. (R)	Route 3, Denmark
Brown, 3rd	•Vanderperren, Cletus (D)	Route 5, Green Bay
Buffalo, Pepin and Pierce	York, Stanley (R)	118 N. Third St., River Falls
Burnett and Polk	•Dueholm, Harvey L. (D)	Luck
Calumet	Hephner, Gervase A. (D)	Rte. 1, Box 15, Chilton
Chippewa	•Peloquin, Bruce S. (D)	497 Irvine St., Chippewa Falls
Clark	Kavanaugh, William C. (R)	Miller St., Greenwood
Columbia	Packard, Wesley L. (R)	Route 3, Lodi
Crawford and Vernon	•Lewison, Bernard (R)	11 S. Washington Heights, Viroqua
Dane, 1st	•Anderson, Norman C. (D)	5325 Marsh Rd., Madison
Dane, 2nd	•Nager, Edward (D)	840 Spaight St., Madison
Dane, 3rd	•Uehling, Robert O. (R)	4330 Keating Terrace, Madison
Dane, 4th	Weisensel, Russel R. (R)	Twin Lane Rd., Sun Prairie
Dane, 5th	•O'Malley, David D. (D)	315 W. Main St., Waunakee
Dodge, 1st	•Doughty, Esther S. (R)	211 N. Hubbard St., Horicon
Dodge, 2nd	•Nitschke, Elmer C. (R)	208 Hamilton St., Beaver Dam
Door and Kewaunee	•Johnson, Lawrence H. (R)	Route 2, Algoma
Douglas	•Perala, Reino A. (D)	824 N. 22nd St., Superior
Dunn	Baldus, Alvin (D)	1901 S. Broadway, Menomonie
Eau Claire, 1st	Waters, Wilmer R. (R)	1417 Birney St., Eau Claire
Eau Claire, 2nd	•Mato, Louis V. (D)	Fairchild
Florence and Marinette	•Stevenson, Leslie R. (D)	603 Ogden St., Marinette
Fond du Lac, 1st	•McEssy, Earl F. (R)	361 Forest Ave., Fond du Lac
Fond du Lac, 2nd	•Schwefel, William S. (R)	Route 1, Oakfield
Forest, Oneida and Vilas	•Alfonsi, Paul R. (R)	Minocqua
Grant	•Azim, James N., Jr. (R)	Muscoda
Green and Lafayette	Tregoning, Joseph E. (R)	Route 2, Shullsberg
Green Lake and Waushara	•Jahnke, Franklin M. (R)	Route 3, Markesan
Iowa and Richland	•Bock, Gregor J. (R)	Highland
Iron (See Ashland)		
Jackson and Trempealeau	•Radcliffe, John (D)	Strum
Jefferson	•Wackett, Byron F. (R)	100 Oak Hill Ct., Watertown
Juneau (See Adams)		
Kenosha, 1st	•Molinaro, George (D)	424 44th St., Kenosha
Kenosha, 2nd	Olson, Russell (R)	Bassett
Kewaunee (See Door)		
La Crosse, 1st	•Wartinbee, D. Russell (R)	1444 Wood St., La Crosse
La Crosse, 2nd	•Nuttelman, Norbert (R)	Route 1, West Salem
Lafayette (See Green)		
Langlade and Oconto	•McDougal, Milton (D)	402 Chestnut Ave., Oconto Falls
Lincoln and Taylor	•Sweda, Joseph (D)	Lublin
Manitowoc, 1st	•Kaufman, Eugene S. (D)	918 S. 13th St., Manitowoc
Manitowoc, 2nd	•Bolle, Everett E. (D)	Francis Creek
Marathon, 1st	Vacant	
Marathon, 2nd	•Obey, David R. (D)	515 N. 9th Ave., Wausau
Marinette (See Florence)		
Marquette (See Adams)		
Menominee and Shawano	•Grover, Herbert J. (D)	Route 3, Shawano
Milwaukee, 1st	•Lipscomb, Mark G., Jr. (D)	2120 W. Colfax Pl., Milwaukee
Milwaukee, 2nd	•Jones, Joseph E. (D)	4285 N. 26th St., Milwaukee
Milwaukee, 3rd	Bellante, Joseph F., Jr. (R)	1035 E. Brady St., Milwaukee
Milwaukee, 4th	•Schaeffer, Frank E., Jr. (D)	1623 W. Wisconsin Ave., Milwaukee
Milwaukee, 5th	Sicula, Paul E. (D)	3287 N. 48th St., Milwaukee
Milwaukee, 6th	•Barbee, Lloyd A. (D)	321 E. Meinecke St., Milwaukee
Milwaukee, 7th	•Johnson, William A. (D)	3403 N. 22nd St., Milwaukee
Milwaukee, 8th	Manders, Verna M. (D)	1406 S. 36th St., Milwaukee
Milwaukee, 9th	•Mertz, Edward F. (D)	3112 W. Silver Spring Dr., Milwaukee
Milwaukee, 10th	•Kessler, Frederick P. (D)	1146 N. 33rd St., Milwaukee
Milwaukee, 11th	•Tobiasz, Raymond J. (D)	3145 S. 50th St., Milwaukee
Milwaukee, 12th	Orlich, Sam L. (D)	1307 S. 11th St., Milwaukee
Milwaukee, 13th	•Parys, Ronald G. (D)	1221 E. Clarke St., Milwaukee
Milwaukee, 14th	•Kordus, Robert P. (D)	3457 S. 25th St., Milwaukee
Milwaukee, 15th	•McCann, James A. (D)	3537 N. 95th St., Milwaukee
Milwaukee, 16th	Pabst, Richard E. (D)	457A S. 74th St., Milwaukee
Milwaukee, 17th	•McCormick, John E. (D)	2954 S. Wentworth Ave., Milwaukee
Milwaukee, 18th	Vacant	
Milwaukee, 19th	•Hanna, Daniel D. (D)	639 W. Layton Ave., Milwaukee
Milwaukee, 20th	Klicka, George H. (R)	2115 N. 86th St., Wauwatosa
Milwaukee, 21st	•Lynch, Richard J. (D)	824 S. 120th St., West Allis
Milwaukee, 22nd	•Huber, Robert T. (D)	2228 S. 78th St., West Allis
Milwaukee, 23rd	Devitt, James C. (R)	5151 Root River Pkwy., Milwaukee
Milwaukee, 24th	•Atkinson, William P. (D)	1115 16th Ave., South Milwaukee
Milwaukee, 25th	•Soik, Nile W. (R)	6266 N. Santa Monica Blvd., Whitefish Bay
Monroe	•Kenyon, Kyle (R)	Route 4, Tomah
Oconto (See Langlade)		
Oneida (See Forest)		
Outagamie, 1st	•Froehlich, Harold V. (R)	421 W. 6th St., Appleton
Outagamie, 2nd	•Rogers, William J. (D)	1317 Hillcrest Dr., Kaukauna
Outagamie, 3rd	•Conradt, Ervin W. (R)	Route 2, Shiocton
Ozaukee	•McKay, J. Curtis (R)	Route 1, Box 371, Cedarburg
Pepin (See Buffalo)		
Pierce (See Buffalo)		
Polk (See Burnett)		
Portage	Groshek, Leonard (D)	Route 1, Stevens Point
Price, Rusk and Sawyer	•Hutnik, Willis J. (R)	716 E. Third St., N., Ladysmith
Racine, 1st	•Warren, Earl W. (D)	2809 Virginia St., Racine
Racine, 2nd	•Brown, Manny S. (D)	2817 Ruby Ave., Racine
Racine, 3rd	•Stalbaum, Merrill E. (R)	Route 1, Box 38, Waterford
Richland (See Iowa)		
Rock, 1st	•Mittness, Lewis T. (D)	730 N. Ringold St., Janesville
Rock, 2nd	•Blanchard, Carolyn J. (R)	506 Chamberlain St., Edgerton
Rock, 3rd	•Belting, George B. (R)	2041 E. Ridge Rd., Beloit
Rusk (See Price)		
St. Croix	Boche, Robert M. (R)	R.R., Star Prairie
Sauk	Laper, Oscar (R)	Rock Springs
Sawyer (See Price)		
Shawano (See Menominee)		
Sheboygan, 1st	Otte, Carl (D)	1440 S. 22nd St., Sheboygan
Sheboygan, 2nd	•Gessert, Harry L. (R)	107 Lake St., Elkhart Lake
Taylor (See Lincoln)		
Trempealeau (See Jackson)		
Vernon (See Crawford)		
Vilas (See Forest)		
Walworth	Wilger, Clarence J. (R)	Route 1, Elkhorn
Washburn (See Barron)		
Washington	•Schroeder, Frederick C. (R)	Route 1, Box 150, West Bend
Waukesha, 1st	•Merkel, Kenneth J. (R)	3405 N. Brookfield Rd., Brookfield
Waukesha, 2nd	•Clemens, Harold W. (R)	272 Lac LaBelle Dr., Oconomowoc
Waukesha, 3rd	•Mathews, Vincent R. (D)	530 Linden St., Waukesha
Waukesha, 4th	•Shabaz, John C. (R)	21425 W. Glengarry Rd., New Berlin
Waupaca	•Anderson, Gerald K. (R)	703 Demerest St., Waupaca
Waushara (See Green Lake)		
Winnebago, 1st	Steinhilber, Jack D. (R)	1748 Southland Ave., Oshkosh
Winnebago, 2nd	•Shurbert, Floyd E. (R)	2904 Oakwood Lane, Oshkosh
Winnebago, 3rd	•Martin, David O. (R)	521 Haylett St., Neenah
Wood, 1st	•Heinzen, Raymond F. (R)	Route 5, Marshfield
Wood, 2nd	•Gee, Harvey F. (R)	170 14th Ave., S., Wisconsin Rapids

•Served in 1965 assembly.

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

LICENSED CHILD WELFARE AGENCIES:

Wisconsin Lutheran Child and Family Service, Inc., 6870 North 76th Street, Milwaukee 53223.

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 53202.

Catholic Social Services of the Archdiocese of Milwaukee, Inc., 207 East Michigan Street, Milwaukee 53202.

Catholic Charities Bureau, 1209 Hughitt Ave., Superior 54881.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse 54601.

Catholic Social Service, 25 S. Hancock, Madison 53703.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay 54305.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 53213.

Lutheran Social Services of Wisconsin and Upper Michigan, 3126 West Highland Boulevard, Milwaukee 53208.

Jewish Family & Children's Service, The Plankinton Bldg., Suite 3185, 161 W. Wisconsin Avenue, Milwaukee 53203.

Methodist Children's Services of Wisconsin, 303 Price Place, Lincoln Bldg., Madison 53711.

PUBLIC AGENCIES:

*Wisconsin Division for Children and Youth, Room 384, State Office Bldg., Madison 53702.

*Milwaukee County Department of Public Welfare, Child Welfare Division, 1220 West Vliet Street, Milwaukee 53205.

LICENSED MATERNITY HOMES:

Lutheran Maternity Home, 1910 South Ave., La Crosse 54601.

*Booth Memorial Hospital, 6306 Cedar Street, Wauwatosa 53213.

Rosalie Hall Maternity Home (Catholic), 1233 North 23rd Street, Milwaukee 53205.

St. Francis Maternity Residence (Catholic), 11th and Market Streets, La Crosse 54601.

Marian Hall (Catholic), 1725 Dousman Street, Green Bay 54303.

Fees for care in licensed maternity homes vary from $150 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

* Nondenominational.

POISON INFORMATION CENTERS . . .

- approved by the Wisconsin Division of Health offer information on the chemical composition of brand-name products on a 24-hour day basis. Files are provided and kept up-to-date by the National Clearinghouse for Poison Control.
- recommend treatment to professional people or in certain emergencies, first aid procedure to lay callers.
- provide treatment for patients.
- keep a record of calls received, treatment advised or given, and disposition of case.
- report monthly to the Division of Health.

are located at:

Eau Claire
Luther Hospital
Phone: 832–6611 Ext. 347

Green Bay
Bellin Memorial Hospital
Phone: 435–5311 Ext. 257

Kenosha
Kenosha Hospital
Phone: 654–5311 Ext. 254

Madison
University Hospitals
Phone: 262–3702

Milwaukee
Children's Hospital
Phone: 344–7100

POISON CONTROL CENTERS . . .

- exist in many hospitals, including those listed above as Poison Information Centers. Not all Poison Control Centers are set up to give 24-hour service.
- provide treatment for patients.
- have standard references on toxicology and can answer many questions about potential poisons and treatment of cases. However, they do not have a complete file of the chemical composition of brand-name products such as the Poison Information Centers have.

This information provided by the

WISCONSIN DIVISION OF HEALTH

P. O. Box 309 **Madison, Wis. 53701**

Your Deadlines and Other "Musts"

Below are some of the deadlines and "musts" of a practicing physician:

TAXES

1. By January 15, 1968, you must pay the final installment of the estimated federal and Wisconsin tax on your 1967 income. This may necessitate an amended declaration by that date if you find that you underestimated 1967 income. A final income tax return for 1967, filed on or before January 31, 1968, accompanied by payment in full of the amount computed on the return as payable, will be treated as an amended declaration as of January 15 for both Wisconsin and federal purposes. Penalties are assessed for certain underestimating of taxes. These penalties and their avoidance are discussed in Section 6 below.

2. By January 31, you must:
   (1) File the employer's return of income taxes withheld in 1967 on Forms W-3 (Federal) and WT-7 (Wisconsin). These are summary report forms for the Forms W-2 (Federal) and WT-9 (Wisconsin), respectively.
   (2) Furnish a statement to employees on Forms W-2 (Federal) and WT-9 (Wisconsin) showing wages paid and amount of tax withheld during the calendar year 1967.
   (3) File fourth quarterly return for 1967 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (4) Furnish a statement to payees to whom interest, rent, compensation not reported on Form W-2 (Federal) and similar types of payments have been paid on Form 1099 (Federal).
   (5) File annual federal unemployment tax return on Form 940 (Federal).

3. By February 28, you must file a summary report on Form 1096 (Federal) attaching copies of the Forms 1099 (Federal) furnished to payees.

4. By April 15, you must:
   (1) File your personal income tax returns on Forms 1040 (Federal) and Form 1 (Wisconsin).
   (2) If a partnership, file your partnership income tax return on Forms 1065 (Federal) and 3 (Wisconsin).
   (3) File and furnish a copy to payees to whom interest, rent, compensation not reported on Forms WT-9 (Wisconsin) and similar types of payments have been paid on Form 9b (Wisconsin).

5. During 1968, you must:
   (1) File quarterly returns by April 30, July 31, and October 31 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (2) File quarterly Wisconsin employer's unemployment compensation reports by the dates stated on the Form UC-101 furnished quarterly by the Department of Industry, Labor and Human Relations.

6. Estimates of Income; Quarterly Adjustments; Penalties.

   The first quarterly estimate of your 1968 income must be shown on Wisconsin and federal declaration forms which have to be filed, together with the estimated tax then due, by April 15, 1968. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1968. As to the final installment due in January, 1969, follow the alternative procedure described in Section 1, above.

   Excluding cases of willful understatement, a penalty is provided for underpaying taxes on declarations of estimated income. This penalty is a 6 percent assessment computed for each installment date on the difference between the amount paid and 80 percent of the amount which should have been paid. The penalty can be avoided if your quarterly installment payments meet one of four exception provisions following. (1) You may pay an amount at least equal to the tax shown on your return for the preceding taxable year. (2) Or, you may estimate your tax on the facts shown on your return for the preceding taxable year, but using current tax rates and personal exemptions. (3) Or, you may pay with each quarterly installment an amount at least equal to 80 percent of a tax then computed as if your income for the balance of the year remaining were to continue at the same rate. (4) Or, you may pay with each quarterly installment an amount at least equal to 90 percent of a tax computed at current rates on the actual taxable income for the months preceding each quarterly installment.

7. Comments on Preceding Information.

   The preceding tax information is general and not exhaustive. Alternate methods of fulfilling these tax requirements do exist. Different forms may be required. The forms and instructional sheets furnished with them should be consulted to determine appropriate alternate methods and forms to use.

The deadline dates apply to taxpayers who use the calendar year as their fiscal year.

Returns and filing dates for personal service corporations differ for certain of those discussed.

ANNUAL REGISTRATION IN WISCONSIN

Register with the Secretary of the Wisconsin State Board of Medical Examiners, 1414 South Park Street, Madison, Wisconsin 53715, in the month of January. This registration will be on a form furnished by the Board of Medical Examiners and should be accompanied by the registration fee shown on that form. Sec. 147.175, Wis. Statutes.

ANNUAL NARCOTICS REGISTRATION

1. Register with the District Director, Internal Revenue Service, Milwaukee, Wisconsin, as required by the federal narcotics law, and pay the annual tax of $1.00 *before* July 1, 1968. I.R.C. 1954, Sec. 4751 and 4753. You are subject to penalties for overlooking either the registration or the tax.
2. Notify the District Director, Internal Revenue Service, Milwaukee, Wisconsin, of changes in place or places of business within 30 days to insure the legality of your narcotics license.

REMEMBER TO:

1. Make prompt report to the State Division of Health, State Office Building, 1 West Wilson Street, Madison, Wisconsin 53702, of communicable diseases. Sec. 143.04, Wis. Statutes.
2. File with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days of the event. Otherwise your medical fees are unlawful. Sec. 69.30 (1), Wis. Statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician, or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), Wis. Statutes.
5. Report *immediately* the following deaths, as required by Sec. 966.20, Wis. Statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there was no physician in attendance within 30 days preceding death.
   h. When a physician refuses to sign the death certificate.

Statute Authorizes Gifts of Human Bodies or Parts

The general rule of law, in the absence of a statute to the contrary, is that the surviving spouse or next of kin controls the disposition of the body of a deceased person. At the suggestion of interested physicians the Wisconsin Legislature enacted a statute in 1961 which needs to be better known to those interested in arranging for the gift of human bodies or parts thereof to medical schools or medical banks for certain purposes.

The statute provides as follows:

155.06 Gifts of bodies or parts thereof. (1) Every person of the age of 21 years or older, of sound mind, may make a gift, during his lifetime, of all or any part of his body to any medical school or to any bank handling parts of the body, provided such gift is for scientific, medical or educational purposes. Such a body or parts thereof shall be made available to the medical school or bank after the death of the donor by the person having custody of the body.

(2) Such a gift shall be evidenced by a written instrument, signed by the donor and by 2 competent witnesses who know the signature to be that of the donor.

(3) The gift by any person of all or a portion of his body made pursuant to this statute may be revoked by the donor at any time during his lifetime.

(4) The donee may accept or reject the gift. If the donee accepts, he or his agent may cause to be removed from the body that portion given to the donee. If the entire body is given, it shall not be delivered to the donee or his agent until after the surviving spouse or other person who assumes custody of the body has had an opportunity to provide a funeral service or other last rites for the deceased.

(5) No person, acting in good faith to carry out the written directions of the donor, shall be liable for damages in any civil suit for his actions notwithstanding the fact that, for any reason, the supposed gift is invalid.

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by the provisions of s. 200.26 and by no other law relating to insurance unless such law is referred to in s. 200.26 and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

* COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through May 1967.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president-elect, the secretary, and the treasurer shall be ex officio members of the Council, but without the right to vote, and the president and speaker of the House of Delegates shall be ex officio members with such right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called.

COMMENT: Section 3 was amended in May, 1965.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates. Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated. No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. No individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and no more than a total of six terms of service as councilor shall be permitted. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years. The fourth sentence on number of councilor terms was added in May 1965.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in

its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

COMMENT: In May 1964 this section was amended to call for an interim session, but in May 1966 this provision was repealed effective January 1, 1967.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each forty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

COMMENT: Number used as basis for determining representation changed from fifty to forty in May 1966.

The term "full-paid members," as used in this section, includes regular members of the Society, life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society* by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.
e. On Finances.

COMMENT: Reference Committee on Finances was authorized by the House of Delegates at May 1967 Annual Meeting.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

* Chapter XI, Section 8 was revised in 1958 to require reporting of delegates by the end of the calendar year. This section editorially revised to conform with 1958 amendment.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

COMMENT: In October 1964, the House of Delegates authorized a special committee of ten members, one from each congressional district, to study redistricting.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society thirty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being

made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of WISCONSIN MEDICAL JOURNAL).

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House

of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Commission on Scientific Medicine
- A Commission on Health Information.
- A Commission on Public Policy.
- A Committee on Grievances.
- A Commission on Hospital Relations and Medical Education.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Cancer.

COMMENT: In May 1967, the House of Delegates changed the name of the Commission on Public Relations and Communications to the Commission on Health Information.

Unless otherwise expressly provided in these Bylaws, each of these committees or commissions shall consist of five members, each of whom shall serve for a term of five years, and no person shall serve on any one of the above committees or commissions more than three consecutive terms; nor shall any member serve concurrently on more than one such committee or commission. One member of each of these committees or commissions shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee or commission the original appointments shall be for terms of one, two, three, four and five years, and thereafter for terms of five years each.

The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House of Delegates for the purpose of amplifying or explaining the annual report of the standing committee of which he is a member.

SEC. 2. The Commission on Scientific Medicine shall consist of ten *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the WISCONSIN MEDICAL JOURNAL. Each appointed member shall serve for a period of five years. The Commission on Scientific Medicine shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the scientific affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

COMMENT: Section 2, above, was amended in May 1964 by Resolution No. 30, which increased the number of appointed members from five to ten, and clarified the Commission's responsibility in that it shall be in charge of *scientific* affairs of the Journal.

SEC. 3. The Commission on Health Information shall consist of nine members appointed by the President of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Commission on Health Information shall study, make recommendations, and implement approved activities to improve the distri-

bution of medical service to the public. It shall also be responsible for all matters relating to industrial, rural health and safety. The Commission shall direct the public information and health education programs of the Society and shall assist the component societies in the conduct of similar programs. It shall also conduct an internal professional relations program to encourage active participation of all members in the affairs of the Society.

SEC. 4. The Commission on Public Policy shall consist of seven representatives from the membership at large, a representative from each Scientific Section created under Chapter XIII, Section 1, the president, president-elect, and the secretary. Representatives from the Scientific Sections shall be appointed by the president of the State Medical Society from a panel of three nominees submitted by each section, or in event of the failure of any section to submit nominees, the president may appoint a member from that specialty group. As nearly as possible the terms of one-third of the members representing the Scientific Sections shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three year terms. Representatives from the membership at large shall be appointed pursuant to Section 1 of this Chapter. The Commission may elect its own executive committee of five members.

The Commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

COMMENT: The Commission on Public Policy was completely reconstituted by the House of Delegates in May 1964, by Resolution No. 29.

SEC. 5. The Committee on Grievances is empowered to receive complaints concerning individual physicians or groups of physicians, and initiate investigations under standing rules which it may establish. It may review decisions of local grievance or arbitration committees on appeal therefrom, but nothing in this section shall be construed as inconsistent with the provisions of Chapter VI relating to responsibilities of the Council.

It shall be the purpose of the committee to endeavor to effect an equitable adjustment or understanding, and to resolve such differences between physicians, or between physician and patient or other complainant.

The efforts of the committee may be extended into areas of interprofessional conduct, the development of appropriate codes of interprofessional relations, and its initial responsibility shall be to the Council of the State Medical Society. It shall consist of nine members appointed for terms of three years, one-third of such terms to expire annually.

Consistent with the special purposes of this committee, all committee records and files pertaining to such matters shall be treated as confidential, shall not be open to inspection by other persons, shall not be released for any purpose and shall not be subject to subpoena.

COMMENT: In May 1967, the House of Delegates repealed Section 5 of Chapter VII and substituted the present wording.

SEC. 6. The Commission on Hospital Relations and Medical Education shall consist of nine members, to be appointed by the President, with confirmation by the House of Delegates. As nearly as possible the terms of one-third of the members shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three-year terms.

Its duties shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

COMMENT: In October 1964, the House of Delegates concurred in recommendation that this Commission retain jurisdiction of both hospital relations and medical education.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 9. The WISCONSIN MEDICAL JOURNAL shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of

the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the Wisconsin Medical Journal, and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

COMMENT: Section 6, above, was created by the Council as Resolution No. 27 and adopted by the House of Delegates in May 1964.

SEC. 7. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 8. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona-fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked, suspended, or voluntarily surrendered, shall be dropped from membership automatically as of the date of revocation, suspension, or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the

state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 8, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.

Control of LSD

The Wisconsin Legislature has added LSD and other hallucinogens to the list of "dangerous drugs."

Specifically, Lysergic Acid, LSD (lysergic acid diethylamide), DMT (N-N-Dimethyltryptamine), peyote, mescaline, psilocyn or psilocybin, or any salts, derivatives, compounds, combinations or mixtures thereof and any substances which are chemically identical with such substances have been added to the list of dangerous drugs which may be used by or distributed to the general public only when prescribed by a licensed physician or other person authorized by law to prescribe or distribute such drugs.

In addition to expanding the list of drugs, the Legislature has broadened the penalties for violations of the dangerous drug law. Illegal use of dangerous drugs or possession without intent to sell such drugs is punishable by not more than one year imprisonment or $500 fine or both for the first offense. Penalties for a second or any subsequent offense are imprisonment of not more than two years and a fine of not less than $250 or more than $1,000 or both.

More severe penalties have been created for certain classes of violators. Thus, a "supplier" who is convicted of illegal possession, sale, furnishing or transportation of any dangerous drug may be imprisoned not more than five years or fined not more than $5,000 or both. A supplier is defined by the statute as any unauthorized person who manufactures, sells or gives any dangerous drug defined under this section for the use of any person for whom such drug has not been prescribed by a practitioner or who in any way delivers such contraband material to anyone he intends to induce to become a user.

In addition, punishment of not more than five years in prison or not more than $2,500 fine or both has been created for any person who intentionally advises, induces or encourages, directly or by any other means, another to commit a violation of the dangerous drug law.

The burden of proving that one should not be prosecuted under the "dangerous drug law" because of an exception, excuse, proviso or exemption contained in the law has been placed on the defendant. This means that if arrested and tried for a violation of the dangerous drug law, a physician or pharmacist who dispenses such drug would be required to prove that he fits within an exception.

Reference: Chapter 93, Laws of 1967, State of Wisconsin.

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

"March of Medicine" is in its 22nd consecutive year of radio broadcasting. The programs, which are tape recorded, feature H. Kent Tenney, M.D., discussing various health problems with a lay person who is called "Your Medical Reporter." At present 52 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Day*	*Time*
WATK	Antigo	Saturday	8:45 a.m.
WHBY	Appleton	Wednesday	7:05 p.m.
WATW	Ashland	Saturday	11:15 a.m.
*WLBL	Auburndale	Wednesday	9:15 a.m.
WWIS	Black River Falls	Saturday	10:00 a.m.
*WHSA	Brule	Wednesday	9:15 a.m.
*WHKW	Chilton	Wednesday	9:15 a.m.
WAXX	Chippewa Falls	Saturday	1:15 p.m.
*WHWC	Colfax	Wednesday	9:15 a.m.
*WHAD	Delafield	Wednesday	9:15 a.m.
WERL	Eagle River	Saturday	9:45 a.m.
WBIZ	Eau Claire	Sunday	6:45 p.m.
KFIZ	Fond du Lac	Sunday	10:45 a.m.
WNFL	Green Bay	Saturday	5:10 p.m.
WHSM	Hayward	Saturday	10:15 a.m.
*WHHI	Highland	Wednesday	9:15 a.m.
*WHLA	Holmen	Friday	10:30 a.m.
WKAU	Kaukauna	Saturday	9:45 a.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WLDY	Ladysmith	Saturday	9:15 a.m.
WMIR	Lake Geneva	Sunday	8:45 a.m.
WHA	Madison	Wednesday	9:15 a.m.
*WHA-AM	Madison	Wednesday	9:00 a.m.
*WHA-FM	Madison	Wednesday	9:00 a.m.
WIBA	Madison	Saturday	1:15 p.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Sunday	10:30 p.m.
WDLB	Marshfield	Saturday	9:15 a.m.
WRJC	Mauston	Saturday	10:15 a.m.
WIGM	Medford	Saturday	9:45 a.m.
WMNE	Menomonie	Thursday	2:45 p.m.
WEKZ	Monroe	Sunday	4:30 p.m.
WNAM	Neenah	Sunday	7:05 p.m.
WCCN	Neillsville	Saturday	9:00 a.m.
WPFP	Park Falls	Saturday	5:15 p.m.
WSWW	Platteville	Saturday	11:15 a.m.
WPDR	Portage	Thursday	10:45 a.m.
WIBU	Poynette	Thursday	2:35 p.m.
WPRE	Prairie du Chien	Saturday	9:45 a.m.
WRJN	Racine	Sunday	6:15 p.m.
WRDB	Reedsburg	Wednesday	8:30 a.m.
WOBT	Rhinelander	Sunday	12:45 p.m.
WJMC	Rice Lake	Saturday	8:30 a.m.
WCWC	Ripon	Saturday	10:45 a.m.
WTCH	Shawano	Saturday	6:20 p.m.
WDOR	Sturgeon Bay	Tuesday	9:05 a.m.
WTRW	Two Rivers	Wednesday	11:00 a.m.
WISV	Viroqua	Saturday	8:45 a.m.
WTTN	Watertown	Friday	11:30 a.m.
*WHRM	Wausau	Friday	10:30 a.m.
WSAU	Wausau	Saturday	5:15 p.m.
WBKV	West Bend	Saturday	10:30 a.m.

*Radio stations in the state network.

STATE MEDICAL SOCIETY OF WISCONSIN

330 EAST LAKESIDE STREET

MADISON, WISCONSIN

The "Home" of the State Medical Society on the south shore of Lake Monona houses the Wisconsin Medical Journal, the Society's Blue Shield plan, general administrative offices, dining room, meeting room, and Council room. Nearly 200 committee and other meetings are held here annually.

Services to Members

Health Educational Activities

Voluntary Health Agency Contacts

Student Loans

Grievance Services

Museum of Medical Progress and Stovall Hall of Health

Executive Office Services

The Wisconsin Medical Journal

Life Insurance

Disability Income Protection

Wisconsin Work Week of Health

WPS Protection

Open Panel Program under Workmen's Compensation

Postgraduate Education Programs

Physician Placement

Medicolegal Consultation

Public Relations

Legislative Representation

Governmental Agency Contacts

Medical Economic Advice

SEE INSIDE BACK COVER FOR MAP GIVING THE LOCATIONS OF THE STATE MEDICAL SOCIETY COMPLEX OF BUILDINGS

Members, State Medical Society of Wisconsin*

Adams:
Janssen, M. L.
Weihe, A. R.

Adell:
Bemis, I. M.

Algoma:
Galang, L. L.
Hopkins, R. G.
March, J. F.
Papendick, D. E.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Arneson, O. N.
Byrne, W. R.
Dasler, H. A.
Ford, K. K.
Marra, M. G.
Schroeder, Daniel J., Jr.
Whitlark, F. L.

Antigo:
Beattie, B. W.
Blink, D. V.
Cromer, R. W.
Curran, W. P.
Fox, T. C.
Garbisch, F. H.
Garritty, J. E.
Lambert, J. W.
McKenna, J. E.
Moore, G. E.
Roth, E. J.

Appleton:
Anderson, J. G.
Bonner, J. N.
Bravick, D. D.
Brei, F. A.
Carlson, G. W.
Chandler, W. W.
Claypool, Blaine, Jr.
Cunningham, P. M.
Curry, J. C.
Dafoe, W. A.
Danford, H. G.
DeCock, R. D.
Dungar, C. F.
Engstrom, D. P.
Erchul, J. W.
Evangelista, T. L.
Fenlon, C. E.
French, G. A.
Gallaher, D. M., Jr.
Giffin, W. S.
Gmeiner, J. E.
Graves, M. D.
Green, C. J.
Gross, H. T.
Grubb, W. B., Jr.
Hale, William H.
Hamel, H. H.
Harris, J. S.
Hauch, F. M.
Haza, B. J.
Hodges, P. C., Jr.
Huberty, F. J.
Kagen, M. S.
Keane, K. M.
Kennedy, R. O.
Kitzerow, E. B.
Konz, S. A.
Laird, J. W.
Landis, R. V.
Loescher, T. M.
Luther, T. W.
McCanna, P. R.
Meighan, P. P.
Meyers, C. L.
Mielke, J. E.
Miller, E. J.
Mueller, G. F., Jr.
Neidhold, C. D.
Nichols, G. P.
O'Boyle, R. F.
Petersen, G. J.
Plouff, L. T.
Querol, J. T.
Raney, E. H.
Rankin, F. J.
Reichle, R. I.
Richards, W. R.
Russell, J. H.
Ryan, T. A.
Santos, G. P.
Savage, G. W.
Siegrist, K. J.
Simenson, R. S.
Slette, D. R.
Sullivan, J. F.
Taylor, A. C.
Veum, J. S.
Warren, J. L.
Weissler, J. B.
Williams, L. P.
Wright, Frank, Jr.
Young, J. J.
Zeiss, E. J.
Zeiss, J. C.

Arcadia:
Chisholm, T. P.

Argyle:
Hunter, R. E.

Ashland:
Bargholtz, W. E.
Grand, C. A.
Jauquet, J. M.
Koeller, A. A.
Kreher, J. E.
Larson, H. H.
Mercer, W. C.
Morrow, K. A.
Prentice, B. C.
Prentice, J. W.
Sandin, H. V.
Sneed, R. J.
Stanley, R. A.
Tucker, W. J.

Athens:
Regehr, E. H.

Augusta:
Moland, O. G.
Thieda, E. S.

Baldwin:
Grieben, L. R. J.
May, J. A.
Olson, C. A.
Sargeant, G. M.
Torkelson, L. B.

Bangor:
Ruppenthal, K. P.

Baraboo:
Edwards, A. C.
Hannan, K. D. L.
Hansel, R. G.
Holmen, G. J.
Huth, M. F.
Pearson, C. R.
Siebert, J. T.
Weston, E. L.

Barron:
MacMillan, D. G.
Strang, C. J.
Whaley, R. C.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Bayley, H. G., Jr.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Cook, R. S.
Corso, Xavier
Damon, R. A.
Davis, T. C., Jr.
Drescher, G. G.
Erickson, N. W.
Funcke, Wm. E.
Glunz, P. R.
Klomberg, G. H.
Kores, A. B.
Link, D. L.
Qualls, C. L.
Richards, W. G.
Ritzenthaler, D. O.
Roberts, R. R.
Rowan, T.
Schulz, N. H.
Snook, W. H.
Szweda, J. A.
Taake, E. R.
Urbanek, R. E.
Vrabec, A. P.
Way, R. W.
Welsch, J. M.
Wohlwend, E. B.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Beloit:
Babb, J. L.
Baldwin, R. M.
Beltran, J. C.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Chancey, R. L.
Fitzgerald, W. M.
Flarity, T. H.
Frank, Jordan
Glesne, O. G.
Greenfield, B. E.
Gunderson, R. H.
Jones, E. T.
Kasten, H. E.
Kishpaugh, H. W.
Kleppe, L. W.
Lakritz, L. W.
Lang, T. J.
Matthews, G. C.
Mauermann, W. J.
Pollard, W. H., Jr.
Pruett, W. A.
Qui, F. L.
Raube, H. A.
Sanderson, R. J.
Scholten, W. A., Jr.
Schwaegler, R. R.
Springberg, J. C.
Thayer, R. A.
Tuftee, A. O.
Twyman, A. H.
Wagelie, R. G.
Woodington, G. F.

Berlin:
Gimenez, A. R.
Koch, H. C.
Koch, J. C.
Osicka, S. R.
Schmidt, E. M.
Seward, L. J.
Sievers, D. J.

Big Bend:
Raschbacher, J. L.

Birnamwood:
Damp, O. E.

Black River Falls:
Daniells, A. S.
Holder, R. L.
Krohn, Eugene
Krohn, Robert
Noble, J. H.
Thurow, R. M.

Blair:
Schneider, O. M.

Bloomer:
Asplund, M. W.
Clauson, C. T.
Hudek, D. F.
Murphy, P. W.

Bloomington:
Edwards, P. K.

Bonduel:
Grover, W. W., Jr.
Stuff, Patricia J.

Boscobel:
Freymiller, E. F.
McNamee, J. R.
Mueller, C. E.
Randall, E. M.

Brandon:
Adams, H. G.

Brillion:
DeArteaga, Julio

Brodhead:
Stuessy, M. W.

Brookfield:
Bemis, E. L.
Brown, D. H.
Deeds, E. C.
Jennison, M. R.
Jurisic, Anthony
Luedke, D. M.
Mann, D. H.
Meves, T. F.
Nemcek, A. A.
Owen, N. L.
Pavlic, R. S.
Restrepo, Roberto
Roth, D. A.
Sewell, R. H.
Stoklos, Michael
Teresi, J. L.
Toepfer, R. A.
Viel, R. S.
Werts, K. G.
Wood, D. L.
Wright, I. V.

Brownsville:
Friedrich, L. E.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Baker, D. J.
Batsleer, R. L.
Erickson, L. V.
Gander, E. P.
Granzeau, H. W.
Krismer, G. J.
McNeel, Laird
Sroka, Wm. C.
Van Liere, J. D.
Wheaton, R. C.

Butler:
Schoeneman, R. H.

Butternut:
Boldt, R. E.

Cadott:
Bowe, C. T.
Haines, B. J.
Zenner, C. E.

Cambridge:
Amundson, K. K.
Nemec, George, Jr.

Campbellsport:
Hoffmann, L. A.

Casco:
Kerscher, E. J.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Huckaby, A. L.
Hurth, O. W.

* As of Dec. 31, 1967.

Katz, H. J.
Kippenhan, J. E.
Misch, Allen

Cedar Grove:
Jensen, J. S.

Chetek:
Adams, R. W.
Bannister, F. M.
Clarke, G. S.

Chilton:
Humke, K. R.
Knauf, J. W.

Chippewa Falls:
Brown, F. J.
Carlson, S. D.
Danl, D. A.
Graber, Rex E.
Hatleberg, C. B.
Hatleberg, E. A.
Henske, W. C.
Kemper, C. A.
Picotte, L. W.
Rahn, B. F.
Sazama, F. B.
Sazama, J. J.
Windeck, J. L.

Clear Lake:
Campbell, L. A., Jr.

Clinton:
Mejia, G. B.
Pili D. B., Jr.
Thomas, W. O.

Clintonville:
Arnold, W. G.
Bate, L. C.
Caskey, H. S.
Topp, C. A.

Cochrane:
Meili, E. A.

Colby:
Koch, James W
Pfefferkorn, E. D.

Coleman:
Graner, L. H.

Colfax:
Earnhart, Harlan
Felland, O. M.

Colgate:
Domann, W. G.
Stein, R. W.

Columbus:
Cheli, C. F.
Poser, J. F.
Poser, R. F.
Shearer, C. E

Cornell:
Hendrickson, R. L.

Cottage Grove:
Vogt, G. H.

Crandon:
Moffet, D. V.
Rathert, Burton S.

Crivitz:
Settlage, H. A.

Cross Plains:
Lappley, W. F.

Cuba City:
King, C. S.
Stone, M. M.
Taylor, H. W., Jr.

Cudahy:
Chelius, C. J.
Cornell, J. W.
Fine, J. M.
Fons, J. W., Jr.
Frederick, J. J.
Homsey, J. J.
Jerofke, A. M.
James, R L.
Kash, S. H.
Lando, D. H., Jr.
Landsberg, Manfred
Latorraca, Rocco
Marcich, Z. P.
Nepomuceno, Ruben A.
Nuyda, D.
Oddis, N. A.
Potos, W. B.
Reynoso, Gustave
Tabet, R. C.
Vitulli, V. N.

Cumberland:
Anderson, R. M.
Jirsa, H. O.
Lund, R. E.

Darlington:
McGreane, N. A.
Olson, Lyle L.
Ruf, D. F.

Deerfield:
Ingwell, C. L.

De Forest:
Grinde, J. M.

Delafield:
Olsen, L. C. J.

Delavan:
Galgano, R. S.
Martin, J. E., Jr.
O'Keefe, F. L.
Roesler, M. J.
Smiley, G. A.
Werbel, H. J.
Woods, Wm. C.

Denmark:
Hering, G. V.
Michna, C. T.

De Pere:
Keiser, O. S.
Levitas, I. E.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

De Soto:
Bolstad, H. A.

Dodgeville:
Buckner, H. M.
Downs, D. R.
Hamilton, W. P.
Morton, H. H.
Rasmussen, N. G.

Dousman:
Pecarski, Miodrag

Durand:
Bryant, R. J.
Myers, M. E.
Springer, J. P.

Eagle River:
Colgan, J. J.
Jacobson, L. L.
Oldfield, R. A. A.

East Ellsworth:
Klaas, F. B.

East Troy:
Kohn, Louis

Eau Claire:
Aitken, H M.
Anderson, F. G.
Aronson, Willard
Bates, P. J.
Beckfield, W. J.
Beebe, G. W.
Bjurstrom, R. O.
Brousseau, E. R.
Brown, J R.
Brown, R. C.
Buckley, R. A.
Cameron, W. G.
Dibble, J. B.
Fink, R. J.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
Gericke, J. T., Jr.
German, K. L.
Giffen, G. G.
Gonlag, Harry
Griffith, D. R.
Haag, A. F.
Halgrimson, K. W.
Henke, F. W.
Henke, S. L.
Hilker, A. W.
Hill, E. F.
Hoff, D. E.
Hudson, R. F.
Huston, H. C.
Ihle, C. M.
Kass, R. M.
Kelley, W. M.
Kennedy, R. L.
Kilkenny, T. E.
Kinsman, F. C.
Klein, A. J.
Larkin, W. B.
Lorenz, A. A.
Lotz, R. M.
Manz, W. R.
Martins, J. K.
Mautz, W. T.
McAfee, G. D.
Mildelfart, Peter A. H.
Miller, D. F.
Miller, G. E.
Moberg, T. D.
Nester, H. D.
Nezworski, L. G.
Niver, E. O.
Ostenso, R. S.
Owen, G. E.
Paulson, W. O.
Raymond, L. A.
Richards, R. R.
Schulz, Emil
Sorensen, H. E.
Spelbring, P. G.
Sperry, V. A.
Stewart, K. E.
Strand, R. C.
Thimke, H. E.
Tobin, J. M.
Wahl, G. E.
Walter, K. E.
Walter, Wm.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B.

Edgar:
Schulz, H. A.

Edgerton:
Boulet, W. J.
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Pavlik, K. K.
Shearer, T. M.
Sumner, W. C.

Elcho:
Dailey, D. W.

Elkhart Lake:
Heiden, H. H.
Martineau, J. E.

Elkhorn:
Bill, K. C.
Helmbrecht, M. G.
Mol, H. R.
Petersen, R. D.
Rawlins, J. A.
Rogers, R. J.
Sorenson, E. D.
Wade, Chester

Ellsworth:
Jonas, E. R.

Elm Grove:
Bauer, C. K
Bauer, K. T.
Carey, Larry
Denio, M. J., Jr.
DiMiceli, Ettore, Jr.
Dudenhoefer, P. A.
Erwin, C. J. R.
Erwin, C. P.
Grade, J. O.
Hanauer, M. M.
Hepperla, R. L
Klingbeil, R. E.
Manhart, R. A.
Mateicka, W. E.
Millington, P. E.
Myers, S. C.
O'Connor, T. M.
Redlin, R. R.
Rouman, W. C.
Settima, A. L.
Shockley, B. F., Jr
Van Gilder, J. H.
Wendt, W. P.
Wisniewski, J. H.
Zurheide, H. J.

Elmwood:
Springer, F. A.

Elroy:
Balder, R. B., Jr.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.
Shields, C. H., Jr.

Fond du Lac:
Becker, N. O.
Benneyan, R. N.
Bissegger, Arnold
Borsack, K. K
Carlovsky, R. E.
Cerny, F. J.
Charles, J. E
Cullen, R. E.
Devine, J. C.
Flanagan, C. M.
Gardner, L. C.
Guth, H. K.
Hagel, Hans
Huebner, J. S.
Hutter, A. M.
Jones, L. E.
Keenan, L. J.
Kendell, W. G.
Kief, H. J.
Koll, J. H.
Lawrence, D. L.
Leonard, C. W.
Liewen, B. E.
Longstreth, C. R.
Mauthe, Howard
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Meisinger, G. F.
Myers, W. E.
Pallin, Josephine N.
Parrish, J. G., Jr.
Pawsat, E. H.
Peters, John
Peterson, C. R.
Rupple, J. H.
Schroeder, R. W.
Shahrokh, D. K.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sisk, J. A.
Smith, D. A.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.
Theis, E. H.
Theisen, S. A.
Thomas, H. R., Jr.
Treffert, D. A.
Twohig, D. J., Jr.
Vetter, E. W.
Vrtilek, M. R.
Waffle, R. L.
Waldschmidt, W. J.
Wier, J. S.
Wojta, W. C.
Yockey, J. C.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Aufderhaar, H. W.
Beran, F. V.
Gueldner, L. H.
Handeyside, R. G.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Russell, J. C.
Sholtes, C. A.
Vognar, S. F.

Fox Point:
Peters, L. M.
Silberman, Jack
Thompson, L. H.

Franklin:
O'Leary, W. J., Jr.

Franksville:
Gass, H. I.
Harris, W. C.

Frederic:
Andrews, W. C.
Fischer, W. A.
Schwab, D. F.

Fremont:
Gloss, A. J.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Genoa City:
Dekker, Cornelis

Germantown:
Lastrilla, R. S.

Gillett:
Klutzow, F. W.

Glendale:
Brazy, R. R.
Mendeloff, Elton
Truszkowski, A. J.
Wegmann, G. H

Glenwood City:
Limberg, A. W.
Limberg, P. W.

Grafton:
Fueredi, Adam
Pelant, K. F.
Seldl, J. A.

Grantsburg:
Hartzell, R. L.
Hartzler, P. L.

Green Bay:
Adamski, V. D.
Andrew, R. C.
Angus, D. C.
Austin, S. D.
Benkendorf, Charles
Beno, T. J.
Blackburn, M. D., Jr.
Boersma, J. J.
Bramschreiber, J. L.
Brault, R. G.
Brusky, A. H.
Brusky, E. S.
Caffrey, J. F.
Clark, E. V., Jr.
Cook, F. D.
Crawford, C. W.
Danaher, H. H.
Dega, F. J.
Denys, G. F.
Dettmann, J. E.
Donarski, D. P.
Draheim, J. H.
Dupont, A. J.
Edelblute, L. H.
Erickson, M. R.
Falk, M. J.
Forbes, K. A.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Gallagher, D. J.
Gehring, J. V.
Goelz, J. R.
Grace, J. B.
Green, J. R.
Griggs, S. L.
Groessl, P. J.
Gruesen, R. A.
Guthrie, J. M., Jr.
Hagerty, W. T.
Haines, A. W.
Hammes, D. A.
Hart, L. E.
Heitzman, H. H.
Hitch, O. M.
Hoegemeier, H. W.
Hoops, H. J., Jr.
Jensen, R. E.
Johnston, R. E.
Kaftan, G. R.
Kaufman, J. E.
Killeen, E. R.
Killins, J. A.
Killins, W. A.
Kuehl, F. O.
Kulkoski, Bernard
Kullerstrand, D. S.
Leicht, T. R.
Le Mieux, G. E.
Lynn, T. E.
Mackey, J. P.
MacMullen, Wallace, II
Marnocha, J. R.
Martin, J. E.
McCarey, Arthur J.
McCormick, R. A.
McGuire, G. E.
McNeal, W. E.
Mickle, K. C.
Miller, L. C.
Mills, J. M.
Milson, B. I.
Milson, Louis
Mokrohisky, J. F.
Myers, R. L.
Nadeau, E. G.
Nadeau, E. G., Jr.
Nellen, J. W.
Neu, V. F.
Nicolaus, W. H.
Ottum, J. A.
Oudenhoven, R. C.
Philipp, L. D.
Rahr, H. C.
Rian, Oliver
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Sandmire, H. F.
Schibly, W. J.
Schmidt, R. T.
Schneider, W. F.
Schumacher, J. P.
Sehring, F. G.
Shea, D. W.
Sherwood, D. L.
Shinners, G. M.
Sipes, D. R.
Slightam, P. E.
Smith, C. C.
Stauff, G. R.
Stiennon, O. A.
Stoehr, B. J.
Stoll, W. M.
Sullivan, Donel
Terner, E. A.
Theiler, G. J., Jr.
Thompson, L. L.
Troup, R. H.
Troup, R. L.
Troup, W. J.
Urban, Frank
Utrie, J. W.
Von Heimburg, Roger
Wallerius, J. F.
Wochos, R. G.
Wunsch, C. A.
Zucker, K. L.

Greendale:
Brown, R. J.
Kowalski, T. H.
Kuglitsch, E. F.
Taugher, P. J.
Wengelewski, H. B.
Westley, William, Jr.

Greenfield:
Mohanty, R. K.
Weis, T. W.

Green Lake:
Barbour, J. H.
Leininger, A. T.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Altstadt, J. F.
Bottum, M. W.
Clemence, J. A.
Czajka, J. J.
Damiano, N. F.
Everts, E. L.
Gillespie, C. J.
Grosshandler, S. L.
Jachowicz, R. B.
La Susa, T. J.
Pierce, D. F.
Sortor, R. F.
Wolf, R. C.

Hartford:
Algiers, J. L.
Arrambide, George
Hoffmann, J. G.
Hoffmann, W. C.
Kern, T. J.
Mally, M. J.
Monroe, M. E.
Nickels, R. J.
Quackenbush, E. C.
Quandt, V. V.

Hartland:
Chambers, R. K.
Ridley, J. F.
Samuelson, Clarence

Hawthorne:
Farias, O. A.

Hayward:
Baertsch, L. M.
Callaghan, D. H.
Sahs, M. H.
Stang, H. M.
Wyant, M. E.

Hazel Green:
Farbstein, M. E.
Klein, G. J.

Hilbert:
Pinney, J. C.

Hillsboro:
Boston, T. E.
Sanford, L. L.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, F. A.
Schutz, W. J.

Hortonville:
Bergwall, J. G.
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Timp, L. F.

Hurley:
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

Independence:
Meyer, C. F.

Iola:
Hollero, N. J.

Jackson:
Albrecht, J. E.

Janesville:
Apfelbach, G. L.
Baker, C. S.
Baumgartner, M. M.
Betlach, Dorothy W.
Betlach, Eugene H.
Chicks, C. O.
Clark, W. T.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gredler, G. P.
Gutmann, G. E.
Hansen, T. R.
Hartlaub, E. S.
Holland, R. A.
Karzel, R. P.
Knepel, Donald
Koch, V. W.
Kochell, R. L.
Kronquist, G. E.
Lakritz, Amrum
Levin, Harland
Llewellyn, M. B.
McNichols, E. F.
McSweeny, A. J.
Nash, C. B.
Neeno, Katsumi
Nienhuis, H. D.
Nolta, R. T.
Nuzum, T. O.
O'Brien, J. N.
Odland, P. K.
Otterholt, E. R.
Overton, R. S.
Pember, J. F.
Pennepacker, J. S.
Peters, E. E.
Peterson, Geo. H.
Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Russo, F. R.
Sabado, E. F.
Sargeant, T. S.
Schroder, John R.
Schroeder, Jack D.
Sholl, P. R.
Smith, D. A.
Snodgrass, H. M.
Thomas, G. L.
Tordoff, J. J.
Tregoning, P. C.
Vogel, T. L.

Jefferson:
Busse, A. A.
Quandt, C. E.
Quandt, R. W.
Siedenburg, Richard

Johnson Creek:
Wendt, F. A.

Juneau:
Haessly, F. G.
Heath, H. J.

Kaukauna:
Bachhuber, A. E.
Bachhuber, A. M.
Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Jeffrey, J. S.
Russo, J. G.
Sklbba, J. P.
Wolfmeyer, W. W.

Kenosha:
Ambro, P. J.
Armstrong, G. F.
Ashley, R. W.
Balcjunas, Vitoldas
Barnes, E. H., III
Barreto, R. S.
Bilak, R.
Bjork, H. A.
Bode, M. J.
Bonell, B. T.
Brooks, K. H.
Burhani, A. W.
Burnett, R. G.
Capelli, P. A.
Conzelman, D. R.
Creighton, L. H.
Creswell, C. M.
Cruz, M. R.
Davin, C. C.
Davis, D. W.
DeFazlo, S. F.

Donnell, W. S.
Duncan, J. T., Jr.
Fai, L. L.
Ferwerda, J. R.
Fraser, W. E.
Garren, J. T.
Goldstein, D. N.
Graves, J. P.
Halfon, Nesim
Hauschild, W. A.
Heck, J. A.
Hill, B. Spalding
Holt, S. H.
Horsley, D. B.
Kent, L. T.
Kleinpell, W. C.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Meeter, U. L.
Mercado, R. C.
Milliken, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr.
Olsman, Louis
Pamukcu, F.
Pearson, J. B.
Pechous, C. E.
Pechous, C. E., Jr.
Peterson, C. E.
Powell, R. A.
Rafferty, H. P.
Rattan, W. C.
Rauen, L. M.
Richards, J. N.
Ruehlman, D. D.
Rufflo, A. F.
Sattler, C. A.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Swift, W. J.
Turner, Lewis, III
Wadina, G. S.
Wagner, H. B.
Weber, G. R.
Welsch, R. G.
Whetstone, O. H.
Williams, F. C., Jr.
Wilson, R. E.
Wood, Fredrick, Jr.

Kewaskum:

Edwards, R. G.

Kewaunee:

Lanier, A. S.
Lanier, Patricia F.
Nesemann, R. M.
Wits, E. W.

Kiel:

Nauth, D. F.
Schultz, W. F.
Theiler, A. C.
Twohig, G. J.

Kimberly:

Gage, Ralph S.
Knoedler, W. H.

King:

McGinnis, H. J.

Kohler:

Gascoigne, C. C.
Rowe, D. M.

La Crosse:

Aiken, R. E.
Alvarez, Ubaldo
Anderson, E. M.
Anderson, N. P.
Anderson, P. D.
Bach, A. C.
Belber, C. J.
Brailey, A. G., Jr
Britt, A. G.
Buchman, D. M.
Carlsson, E. S.
Cejpek, K. O.
Cook, A. A.
Copps, S. C.
Corser, D. H.
Da Costa, W. C.
Dalton, R. M.
Dietz, P. C.
Durst, J. B.
Egan, G. J., Jr.
Ellenz, G. B.
Ernst, F. W.
Felion, P. L.
Fisher, A. L.
Flynn, R. E.
Fox, J. C.
Gallagher, F. J.
Gallagher, W. B.
Getz, Kaare
Gilbert, R. L.
Goodnough, D. E.
Green, R. M.
Guernsey, Gretchen
Gundersen, A. E.
Gundersen, A. H.
Gundersen, A. L.
Gundersen, Cameron
Gundersen, G. A.
Gundersen, Gunnar
Gundersen, J. H.
Gundersen, S. B., Jr.
Gundersen, T. E.
Haidinyak, A. L.
Haug, S. L.
Hayden, J. W.
Helliesen, P. J.
Hickey, A. W.
Howard, R. S.
Hullck, P. V.
Jones, W. J.
Joseph, L. G.
Kalfayan, Bernard
Keimowitz, R. M.
Leiby, R. W., Jr.
MacEwen, A. R.
Mahairas, G. H.
Mansheim, B. J.
McGarty, M. A.
McKee, D. C.
McMahon, R. E.
McNamara, T. B.
Meis, P. J.
Midelfort, C. F.
Miner, E. B.
Morgan, W. A.
Murphy, G. B., Jr.
Murphy, J. T.
Newcomer, K. L.
O'Meara, M. T.
Perry, E. L.
Phillips, P. W.
Pribek, R. A.
Ramlow, R. W.
Rasmus, R. B.
Richter, J. R.
Satory, J. J.
Scheurich, Mary B.
Schmidt, C. F.
Schmidt, L. R.
Schneeberger, E. J.
Schuldes, R. E.
Sevenants, J. J.
Shealy, C. N.
Shields, J. C.
Simones, J. J.
Sivertson, S. E.
Skemp, C. A.
Skemp, F. C.
Skemp, G. E.
Skemp, J. J.
Skemp, J. T.
Skemp, S. J.
Slungaard, Rolv
Smith, Martin J.
Tankersley, J. C.
Thompkins, D. G.
Uhrich, G. I.
Van Susteren, J. A.
Wahl, J. W.
Watunya, M. J.
Weeth, J. B.
Wolf, F. H.
Yutuc, W. R.

Ladysmith:

Bauer, W. B. A. J.
Bennett, R. P.
Murphy, J. E.
Pagel, H. F.

La Farge:

Lee, Connie

Lake Geneva:

Beattie, J. W.
Bischof, H. F.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H., Jr.
Rauch, A. M.

Lake Mills:

Eck, G. E.
Effenhauser, Manfred
Leering, Hendrik
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G.

Lake Tomahawk:

Craite, E. J.

Lancaster:

Bauman, K. L.
Becher, L. E.
Carey, H. W.
Hillery, G. C.
Houghton, E. M.
McCay, Sophia

Land O' Lakes

Eickhoff, E. C.

Laona:

Castaldo, E. F.
Ovitz, E. G.

Lena:

Rose, J. F.

Little Chute:

Buchanan, K. E.
Van Lieshout, F. X.

Lodi:

Irwin, W. G.

Loyal:

Hable, A. P.

Luxemburg:

Majeski, H. E.

Madison:

Aageson, C. W.
Aguilar-Sincaban, V. M.
Ainslie, R. B.
Albright, E. C.
Albright, J. G.
Allen, J. R.
Allen, J. C.
Allen, Mauery
Allin, R. N.
Anderson, A. D.
Anderson, Jeanne
Anderson, R. B.
Andrew, R. B.
Angevine, D. M.
Ansfield, F. J
Ansusinha, Tamnit
Ashman, H. C.
Backs, M. F.
Backwinkel, K. D.
Bamforth, Betty J.
Barnes, H. P. G.
Barta, R. A., Jr.
Bartlett, W. H.
Batson, J. F.
Bauman, B. J.
Baumblatt, M. J.
Beck, J. P.
Becker, R. M.
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Belknap, E. L., Jr.
Benish, G. A.
Bennett, Maxine
Berg, Mary C.
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Bernard, F. D.
Bernhardt, L. C.
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Blancke, F. W.
Bloodworth, J. M. B., Jr.
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Bohlman, D. C.
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Brandabur, J. J.
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Briggs, R. C.
Brindley, B. I.
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Britton, D. M.
Brodhead, Wm. T.
Brown, J. G.
Bryan, G. T.
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Burke, Myra E.
Burns, E. M.
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Calloway, N. O.
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Carter, H. M.
Celesia, G. C.
Chase, S. L.
Chosy, L. W.
Chunn, A. G.
Clatanoff, D. V.
Clausen, N. M.
Cline, D. W.
Clinton, G. L.
Cohen, Marcus
Collins, R. F.
Connors, C. B.
Connors, D. M.
Cookson, D. U.
Cooper, G. A.
Coryell, J. L.
Cowle, A. E.
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Crocker, L. G.
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Cunningham, M. A.
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Davis, F. A.
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Edland, R. W.
Ehrlich, F. E.
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Epstein, Stephan
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Waters, D. D.
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Weinstein, A. B.
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Westman, J. C.
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Wlrka, H. W.
Wirtanen, G. W.
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Wyner, S. F.
Yale, C. E.
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Yiltalo, W. H.
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Zolot, M. M.

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Banker, R. J.
Binard, J. E.
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MacLean, C. R.
Miller, H. P.
Perry, T. K.
Pick, D. M.
Puestow, R. C.
Radl, C. J.
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Schroeder, N. C.
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Strong, R. G.
Teitgen, T. A.
Thorpe, R. F.
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Moss, K. J.
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Zeratsky, J. D.

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Fletcher, F. W.
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Geitz, Marten
Gordon, R. P., Jr.
Gouze, F. J.
Grlese, G. G.
Haight, R. P., Jr.
Hardacre, J. M.
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Heersma, J. R.
Heywood, R. M.
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Hinke, D. H.
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Kunkel, J. A.
Lawton, B. R.
Lewis, R. F., Jr.
Lohrenz, F. N.
Macht, A. J.
Magnin, George E.
Manier, J. W.

Mason, R. W.
Moffat, N. A.
Mulvaney, J. J.
Nikolai, T. F.
Norfleet, R. G.
Olsen, T. G.
Ottensmeyer, D. J.
Ousley, J. L.
Pederson, D. P.
Porter, G. E.
Potter, R. P
Ptacek, L. J.
Reyes, C N.
Rice, T. J.
Richards, R. N.
River, G. L.
Rowe, R. J.
Rupel, J. W.
Salibi, B. S.
Sattler, J. R.
Sautter, R. D.
Schloesser, L L.
Schorr, W. F.
Silvis, S. E.
Stinson, H. K.
Suits, J. J.
Toyama, W. M.
Vedder, C. A.
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Voss, D. M.
Waters, H. S.
Williams, G. H.
Wink, R H
Zurek, W. Z.

Mauston:

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Griffin, V. M.
Hess, J. S., Jr.
Strong, Jack
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Bachhuber, M. W.
Parish, G. A.

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McFarland:

Arnesen, R. B.

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Meyer, W. W.
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Vakili, Hassein

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Jensen, F. G.
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Larson, O. E.
Nebel, J. R.
Newby, K. G.
Pratt, G. N., Jr.
Schwei, G. P.
Wainscott, P. E.

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Brennan, W. M.
Dawes, R. B.
De Guzman, E.
Dempsey, K. J.
Domann, W. A.
Dougherty, P. J.
Drayer, H. D.
Foley, J. J.
Hardman, D. R.
Harrington, K. J.
Heyrman, D. J.
Hofbauer, T. A.
Hoffman, J. R.
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Riesch, J. D.
Schloemer, H. F.
Schmidt, R. D.
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Melms, F. A., Jr.
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Palmer, K. A.
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Merrill:

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Braun, W. E.
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Lewinnek, Walter
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Derse, F. R.
Devitt, J. S.
Deysach, L. J.
Dhuey, J. N.
Diamond, C. O.
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Docktor, John P.
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Dooley, J. E.
Dorn, A. S.
Dorn, R. G.
Doubrava, Sterling, Jr.
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Dundon, J. R.
Dunker, G. O.
Dunn, Cornelius
Dunst, C. G.
Dvorak, H. J.
Dvorak, Laura
Easom, H. A.
Eby, L. G.
Egan, W. J.
Eichenberger, C. R.
Eisenberg, E. E.
Eisenberg, L. A.
Elconin, A. N.
Elconin, D. V.
Ellison, E. H.
Elson, M. W.
End, Edgar
End, J. A.
Engbring, N. H.
Enzer, Norbert
Epperson, K D.
Epstein, Ely
Erbes, John
Esser, J. H.

Evans, S. M.
Evrard, J. R.
Faber, C. A.
Falsetti, F. P.
Fant, J. R.
Farrell, H. J.
Fechter, F. J.
Feiman, L. H.
Feld, S. M.
Ferroy, C. A.
Fetherston, J. P., Jr.
Fetherston, W. C.
Fick, K. R.
Fidler, Alan B.
Fiedler, H. W.
Fine, R. A.
Finger, W. A.
Finlayson, W. E.
Finn, C. J.
Fisk, N. M.
Fitz, A. E.
Fitzgerald, R. E.
Fitzpatrick, P. J.
Flanary, L. M.
Flatley, T. J.
Fletcher, H. A.
Flint, C. H.
Flood, R. E.
Flynn, G. F.
Flynn, R. T., Jr.
Foerster, F. E.
Foerster, H. R.
Foerster, H. R., Jr.
Foley, D. V.
Foley, T. J.
Foregger, Richard
Forrestal, T. P.
Fox, M. J.
Fox, Meyer S.
Fox, Milton J.
Frackelton, W. H.
Franke, G. H.
Franklin, Emil
Franklin, Isadore
Franklin, R. L.
Frawley, D. D.
Freedman, M. S.
Friedman, B. J.
Friedrichs, E. S.
Frisch, J. G.
Frisch, R. A.
Fritz, R. D.
Fritz, R. J.
Fruchtman, R. B.
Fruth, R. B.
Gaenslen, F. G.
Galasinski, R. E.
Gale, H. H.
Gallen, W. J.
Gandy, T. I.
Garens, R. W.
Garland, T. F.
Garman, J. E.
Garner, L. L.
Garry, M. W.
Gasparri, P. G.
Gaunt, J. J.
Gaynon, I. E
Gebert, W. H.
Gebhard, U. E.
Gecht, E. A.
Geiger, Sara G.
Geigler, J. E.
Geist, J. E.
Gelfman, Morris
Gendlin, N. A.
George, K. S.
Giannattasio, V. A.
Gilbert, Joseph
Gilchrist, R. T.
Giller, Herbert
Gingrass, R. P.
Gingrass, Ruedi P.
Gjud, A. M.
Glassner, D. M
Glicklich, Lucille B.
Glicklich, Marvin
Glienke, C. F.
Glisch, W. P.
Goetz, R. A.
Goldberg, H. M.
Goldberg, Nat.
Goldberg, S. C. B.
Goldberger, Esther W.
Goldberger, R. J.
Goldstein, P. H.
Goodman, J. A.
Goodman, J. S.
Goodman, P. P.
Gorder, A. C.
Gordon, N. F.
Gorens, S. W.
Gorenstein, Leonard
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Gramling, J. J., Jr.
Graziano, S. A.
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Greenberg, Maurice
Gregorski, R. F.
Griffith, J. C.
Groh, J. A.
Grossman, N. M
Grossman, R. E.
Grossman, T. W.
Grossmann, E. E.
Gruender, J. E. M.
Grueninger, A. J.
Guardalabene, Vito
Guhl, J. F.
Gumerman, G. J.
Gute, D. B.
Gutglass, M. F.
Guzzetta, M. M.
Guzzetta, P. C., Jr.
Habbe, J. E.
Habeck, E. A. W.
Hackbarth, D. E.
Hall, Mary A.
Haller, C. K.
Halloran, W. R.
Halser, J. G., Jr.
Hamm, H. J.
Hankwltz, A. W.
Hansen, A. C.
Hansher, Ervin
Hansen, E. R.
Hara, Kinge
Hardgrove, Maurice
Hargarten, L. W.
Harkavy, Raymond
Harkness, J. W.
Harper, C. W.
Harrington, E. T.
Harris, B. A.
Harris, T. A.
Hartwick, J. P.
Haug, J. F.
Haugh, J. J., Jr.
Haushalter, L. E.
Hausmann, P F.
Heckman, M. G.
Heidner, F. C.
Heifetz, E. C.
Heinan, F. C.
Heinzelmann, C. N.
Heise, H. A.
Heller, T. A.
Hellmuth, G. A.
Helm, F. C.
Henschel, A. B.
Hermann, A. H.
Herrington, J. K.
Herrington, R. E.
Herzog, J. V.
Hickey, C. H., Jr.
Hlgh, A. L.
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Hilger, Wm. A.
Hiller, S. J.
Hilliard, G. W., Jr.
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Himes, Joseph
Hinson, R. E.
Hipke, L. W.
Hipke, M. M.
Hirsch, S. R.
Hirschboeck, J. S.
Hitz, J. B.
Hlabac, R. J.
Hodgson, N. B.
Hoelscher, F. E.
Hoelscher, K. K.
Hoffman, Wm. K.
Hofmeister, F. J.
Holbrook, A. A.
Holbrook, A. T.
Holder, D. H.
Hollenbeck, S. W.
Horwitz, S. F.
Hotter, J. T
Houghton, W. J
House, J. W., Jr.
Hovis, W. F., Jr.
Howard, T. J.
Howards, L. A.
Huber, H. H.
Hughson, D. T.
Hunkel, V. H.
Hurley, J D.
Hurley, J. R.
Hurwitz, S. P.
Huston, E. S.
Huston, J. H.
Huston, John
Hutchens, J. E.
Hyslop, V. B.
Ibach, H. F.
Imp, J. F.
Inda, Gregory
Ives, D. G.
Jackson, E. B.
Jacobs, P. A.
Jacobson, F. J.
Jaekels, M. T.
Jahn, R. P.
James, L. J.
Jefferson, R. A.
Jekel, J. M.
Jelenchick, E. J.
Jennings, T. F.
Jermain, L. F.
Jermain, W. M.
Jobling, R. S.
Johnson, Frances
Johnson, H. W.
Johnson, J. A.
Johnson, J. H.
Johnson, K. O.
Johnson, R. C.
Johnson, Rhoda E.
Johnson, W. D.
Johnston, T. L.
Jordahl, Clarence, Jr.
Judge, T. A.
Jurczyk, W. G.
Jurevics, I. R.
Jurgens, G. H.
Jurishica, A. J.
Jurss, Charles D.
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Kagen, A. E.
Kagen, Louis
Kah, W. W.
Kalb, C. H.
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Kanin, H. J.
Karen, Robert
Karlin, H. R.
Karr, J. K.
Kasak, Michael
Kassowitz, K. E.
Kastelic, Robert
Kaufman, K. K.
Kaufman, L. W.
Kay, E. M
Kearns, J. W.
Kebbekus, R. A.
Kelble, J. A.
Kenwood, S. N.
Kerrigan, G. A.
Kersting, D. W.
Keskey, C. W.
Keskey, G. R.
Kienzle, C. J.
Kijner, H. H.
Kilian, A. D.
Kindwall, J. A.
Kling, J. J.
King, J. M.
Kirmse, T. W.
Kissling, A. C.
Klamecki, B. J.
Klees, V. M.
Kleiman, M. W.
Klein, Morris
Kleinerman, L. B.
Kleis, W. J.
Klieger, J. A.
Klink, D. D.
Kloehn, R W.
Klumb, M. G.
Kniaz, Albert
Koch, M. J.
Kocovsky, C. J.
Koenig, R. R
Koepke, D. E.
Kohler, S. H.
Kohn, S. E
Korducki, Stanley A
Korkos, G. J.
Kostich, Zaga
Kottke, M. A.
Kozina, F. J.
Kozina, T. J.
Kramoris, F. H.
Kreitzer, F. V
Krembs, M. A.
Kretchmar, J. S.
Kretchmar, L. H.
Kretchmar, Morris
Kretzschmar, W. A.
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Krill, R. J.
Kritter, F. J.
Kriz-Hettwer, Rose
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Krumenacher, F. P.
Krygier, A. J.
Krygier, W. L.
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Kurzon, Alvin M.
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Kuzdas, J. R.
Kuzma, J. F.
Kwapy, C. R.
LaBissoniere, P. G.
LaPond, D. J.
Landis, C. W.
Lane, G. H.
Lange, R. L.
Langjahr, A. R.
Larkey, Jay A.
Larsen, L. L.
Larson, Craig
Larson, S. J.
Lathers, E. G.
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Lawler, P. J.
Lee, H. J.
Lee, P. A.
Lemann, Jacob, Jr.
Lepley, Derward, Jr.
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Leverenz, R. L.
Levin, A. J.
Levin, J. D.
Levine, Abram
Levinson, C. J.
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Lieberthal, A S.
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Lillie, R. H.
Lindert, M. C. F.
Lindorfer, D. B. J.
Linn, J. C.
Lipo, R. F.
Lipscomb, C. R.
Lipscomb, T. C.
Litzow, J. R.
Locher, C. J.
Lochowitz, N. J.
Lokletz, Howard
Long, C. W.
Longe, W G.
Looze, J. P.
Lopez, Basilio
Louthan, B W.
Lovett, M. N.
Lubar, Sidney
Lubitz, J. M.
Lucas, Paul
Lustok, M. J.
MacGillis, A. J.
Madden, R. F.
Madison, F W
Mahaffey, C. H
Majewski, J T.
Mallin, S. R.
Malloy, D. J.
Malloy, T. G.
Malnekoff, B J
Malone, J. A.
Manago, J. A.
Manley, J. C
Mann, R. W.
Maranan, I. L.
Marino, Rita
Mark, L. K.
Marks, Charles
Marks, J L
Marks, S. A.
Markson, J. W
Markson, L. S
Martens, W. E.
Martin, A. G.
Martin, D. H.
Martineau, E L.
Mason, E. W
Mastalir, L. O.
Mathison, J A
Mattingly, R. F.
Maxey, Louis T.
Maxwell, J. W.
Mayer, H. H.
McCabe, J. O.
McCabe, John
McCabe, R. W.
McCormick, G. E.
McCormick, Thomas F.
McCreadie, S. R.
McDevitt, W. P.
McDuffie, J J.
McKenty, J. D.

McKittrick, N. W.
McLaughlin, B. C.
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Means, J. A., III
Mehigan, D. M.
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Mendeloff, Hyman
Merten, A.N.E.
Meyer, J. M.
Meyer, J. O.
Meyers, Alfred
Mikolajczak, N. A.
Millen, F. J.
Miller, D. D.
Miller, H. L.
Mills, W. R.
Miner, H. B.
Mitcham, LeRoy
Mitz, Morris
Moel, Morris
Molsberry, J. M.
Montenegro, J. V.
Montgomery, E. G., Jr.
Montgomery, R. P.
Montgomery, T. B.
Mookerjee, M. K.
Moore, G. E.
Morbeck, F. E.
Morgan, J. E.
Morgan, S. F.
Morrison, R. C.
Morter, H. V.
Morter, R. E.
Mossey, R. O.
Motamedi, Naghi
Mountain, D. C.
Mroczkowski, C. J.
Muehlhaus F. R.
Mueller, G. F.
Mueller, J. J.
Mueller, K. H.
Mueller, Nina T.
Muenzner, R. J., Jr.
Mufson, J. A.
Mullaney, G. L., Jr.
Mullooly, J. P.
Murphy, F. D.
Narodick, B. G.
Natenshon, A. L.
Natvig, Paul
Nelson, J. W.
Nemeth, Charles
Nevels, Z. J.
Newberg, L. B.
Ney, J. E.
Niland, P. J.
Nimz, R. A.
Nock, G. J., Jr
Noonan, P. J.
Northey, T. M.
Nothum, J. P.
O'Brien, E. J.
O'Connor, R. D.
O'Leary, E. B.
O'Loughlin, P. D.
Olsen, A. H.
Olsen, R. N.
Olson, C. R.
O'Malley, R. J.
O'Neill, E. J.
O'Neill, Philip B.
Oren, Gideon A.
Oswald, Frederick
Ottenstein, H. H.
Otto, Owen
Ovitt, D. W.
Owen, G. C.
Owens, A. J.
Oxman, E. M.
Pagedas, T. C.
Palabrica, A. R.
Palermo, Geo. B.
Palese, J. A.
Pallasch, F. J.
Pandazi, A. A.
Paquette, L. J.
Parks, W. C.
Paulbeck, T. M.
Pelland, P. C.
Pemberton, A. H
Pequet, Archie
Perlson, S. G.
Perssion, Leo B
Peters, B. J.
Petersen, J. R.
Peterson, J. C.
Pfeffer, T. J.
Pfeifer, W. M.
Pfeiffer, O. W.
Phillips, M. F.
Phillips, W. S.
Piaskoski, R. G.
Pick, J. W.
Pisciotta, A. V.
Pittelkow, R. B.
Pleyte, A. A.
Pohle, H. W.
Poindexter, G. W.
Polacek, M. A.
Polacheck, L. J.
Polacheck, W. S.
Poll, Marvin
Pollack, S. K.
Pollard, R. E.
Popp, Albert
Popp, M. J.
Powondra, P. F.
Presti, A. A.
Price, D. J.
Prier, T. A.
Puchner, Thomas
Pugh, G. J.
Pullto, F. J.
Puls, T. B.
Purtell, P. J.
Purtell, R. F.
Purtell, R. F., Jr.
Quick, A. J.
Quitzon, A. F.
Raasch, H. M.
Rabenn, W. B.
Rabin, Allen
Ramin, J. E.
Rand, Harold
Rank, R. T.
Rastetter, J. W.
Rath, E. K.
Ratke, Donald
Regan, J. M.
Regan, J. R.
Reifenrath, I. B.
Reifenrath, W. E.
Reik, R. P.
Reinke, C. C.
Relacion, J. R.
Rettig, E. H.
Rettig, Frank
Reuter, M. J., Jr.
Rice, R. L.
Ridley, J. E.
Rife, C. S.
Rikkers, D. F.
Rinder, R. S.
Ritchie, Gorton
Robbins, L. S.
Rodenbeck, A. F.
Roethke, Anne E.
Rolfs, T. H.
Roncke, G. J.
Rose, Mona
Rose, W. R.
Rosenbaum, F. F.
Rosenberg, S. W.
Ross, F. A.
Rotter, E. J.
Royce, Owen, Jr.
Ruch, D. M.
Ruehl, R. L.
Rueth, J. E.
Ruff, L. L.
Ruflo, R. A.
Ruppa, Rex
Ryan, P. W.
Ryan, T. E.
Sable, M. H.
Sabljak, E. J.
Sackin, H. D.
Sadoff, H. B.
Saichek, R. P.
Sakaguchi, Shimpei
Saketos, T. P.
Salama, E. M.
Salinsky, L. V.
Saltzstein, E. C.
Samter, T. G.
Sander, O. A.
Sanders, A. C., Jr.
Sanfelippo, A. J.
Santer, D. G.
Sargent, J. W.
Sattler, M. E.
Sauter, K. E.
Savino, P. R.
Sawyer, T. R.
Schacht, W. J.
Schaeffer, B. S.
Schalmo, E. H., Jr.
Scheidt, R. A.
Schelble, E. J.
Schelble, J. A.
Schelble, J. P.
Schlomovitz, B. H.
Schlueter, D. P.
Schmidt, A. C.
Schmidt, C. E.
Schmidt, D. K.
Schmidt, E. C.
Schmidt, H. G.
Schmidt, R. A.
Schmitz, J. T.
Schnapp, A. C.
Schneeberger, L. J.
Schneider, C. C.
Schneider, C. R.
Schoenkerman, B. B.
Scholter, E. A. W.
Schowalter, R. P.
Schroeder, C. M.
Schroeder, K. P.
Schuler, F. X.
Schultz, R. O.
Schulz, Irwin
Schutte, A. G.
Schuyler, R. M.
Schwade, L. J.
Schwartz, A. B.
Schwartz, S. F.
Schwartz, W. R.
Schweiger, L. R.
Scrimenti, R. J.
Seefeld, P. H.
Seelman, J. J.
Sella, J. L.
Semler, W. L.
Sender, Neville
Seng, W. L.
Sengpiel, G. W.
Sennett, L. W.
Sepp, I. E.
Servis, L. T.
Shaiken, Joseph
Shaner, G. O.
Shapiro, David
Shapiro, W. D.
Shapson, Milton
Sheehan, E. T.
Sherkow, C. J.
Shindell, Sidney
Shovers, Philip
Silagi, M. J.
Silbar, J. D.
Silbar, S. J.
Sinclair, E. P.
Sinsky, J. E.
Sladky, J. A.
Slamer, J. R.
Slomovitz, Zachary
Slomowitz, Jonathan
Slutzky, Nathan
Smigielski, K. M.
Smith, A. L.
Smith, J. J.
Smith, M. B.
Smith, V. W.
Smuckler, R. H.
Snartemo, R. J.
Snyder, J. F., III
Sorenson, J. M.
Sorenson, R. I.
Sosman, Abe
Southcott, W. C.
Spankus, J. D.
Spear, H. Gladys
Spector, J. A.
Spitz, M. B.
Sproule, R. P.
Sproule, R. T.
Spyres, D. P.
Squier, T. L.
Stageman, J. F.
Stead, W. W.
Steckler, Armin
Stein, P. G.
Stein, P. L.
Steiner, C. M.
Steiner, R. E.
Stemper, J. A.
Stenborg, W. P.
Stergiades, F. G.
Stewart, R. D.
Stewart, W. C.
Stiehl, C. W.
Stobbe, K. C
Stockinger, R. E.
Stockland, Leo
Stoddard, F. J.
Stollenwerk, K. J.
Stone, J. R.
Strass, H. W.
Strassburger, R. H.
Straus, G. D.
Strawn, E. Y.
Stringer, W. H.
Stubenrauch, G. O.
Studley, W. H.
Stula, G. D.
Sullivan, J. M.
Sullivan, J. T.
Sverdlin, A. A.
Swartz, L. W.
Sweet, S. J.
Szymarek, J. E.
Tacke, A. W.
Taira, Yoshiro
Tang, T. T.
Tashkin, E. H.
Tax, A. H.
Taxman, J. E.
Teasley, J. L.
Tegtmeyer, G. F.
Teitgen, R. E.
Temple, J. W.
Temple, R. L.
Teplin, Ervin
Terry, J. W.
Tharinger, E. L.
Thatcher, D. S.
Thiede, W. H.
Thoma, J. W.
Thomas, Lillian M.
Thomas, P. W.
Thomas, W. D.
Thompson, B. W.
Thompson, R. D.
Thomson, N. R.
Thorstensen, A. H.
Thurwachter, L. F., Jr.
Tibbetts, P. G.
Tisone, J. J.
Tolentino, M. G.
Tonkens, S. W.
Toohill, R. J.
Topetzes, G. J.
Torcivia, S. S.
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Tufts, Millard
Turner, C. R.
Turrell, E. S.
Ullrich, D. P.
Unger, G. F.
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Usow, E. J.
Uszler, L. B.
Vaccaro, J. E.
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Waldren, H. M.
Walker, J. A.
Walker, L. J
Wall, Thomas
Wallner, E. F.
Walton, W. B.
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Watry, T. D.
Watson, H. J., Jr.
Watson, R. R.
Watts, Alice D.
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Webb, W. C.
Weber, J. C.
Weber, J. E.
Weber, M. L.
Weil, H. R.
Weingarten, Maxwell
Weinshel, L. R.
Weisel, Wilson
Weisenthal, C. L.
Weisfeld, S. G.
Weisfeldt, S. C.
Weller, R. R.
Wells, Marvin
Welsh, E. C.
Wepfer, J. F.
Werner, D. J.
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Wiegmann, O. A.
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Wilets, J. B.
Wilets, J. C.

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Willson, D. M.
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Wolfe, C. W.
Woloschek, W. J.
Wolter, S. H.
Wong, V. J.
Woodward, G. S.
Worman, L. W.
Worsencraft, H. M.
Wyman, J. F.
Wynn, S. K.
Yatso, M. G.
Yellick, C. W.
Young, H. C.
Young, W. N.
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Zastrow, R. C.
Zautcke, A. B., Jr.
Zawodny, S. E.
Zellmer, J. H.
Zeps, A. A.
Ziegler, C. T.
Ziehl, F. L.
Zillmer, Helen J
Zimmerman, R. C.
Zimmermann, B. M.
Zuege, R. C.
Zupnik, G. R.

Mineral Point:
Hamlin, W. D.
Hohler, E. J.

Minocqua:
Ashe, H. S.
Huber, G. W.
Smith, R. L.

Mishicot:
Nilles, J. E.

Mondovi:
Johnson, D. B.
Sharp, D. S.
Wright, W. E.

Monroe:
Barry, G. R.
Baumann, R. R.
Baumle, C. E.
Bear, N. E.
Brunkow, B. H.
Chandler, Arthur, Jr.
Eckstam, E. E.
Fencil, W. J.
Frantz, J. A.
Frantz, M. H.
Fuller, J. R.
Hein, W. E.
Herzberger, E. E.
Irvin, J. M.
Jaramillo, C. A.
Jew, S. Q.
Kamstra, E.
Kindschi, L. G.
Kundert, F. W.
Maddix, B. L.
Miller, C. O.
Mings, D. E.
Murray, J. F.
Najat, Hushang
Olson, M. J.
Pratt, Mary V. H.
Rush, B. M.
Santiago, F. S.
Springer, D. W.
Staab, W. J., Jr.
Stiles, F. C.
Stormont, J. R.
Villacrez, J. A.
Watt, T. L.
Weeks, J. H.
Weir, J. R.
Wichser, R. F.
Witte, K. B.
Zach, R. G.
Zupanc, E. A.

Montello:
Inman, R. F.

Montfort:
Breier, H. P.

Mosinee:
Beglinger, H. F.

Mount Calvary:
Miller, J. F.

Mount Horeb:
Morrison, M. T.

Mukwonago:
Kern, E. E.
Rosenkranz, W. E.
Zarbock, F. M.
Zwisler, E. E.

Muscoda:
Ackerman, E. T.
Klockow, W. E.

Muskego:
Kelm, G. J.

Neenah:
Anderson, G. R.
Arndt, G. W., Sr.
Beatty, S. R.
Brown, R. C.
Colgan, H. J.
Dedmon, R. E.
Douglas, R. F.
Geldner, Barbara
Geldner, M. M.
Gohdes, P. N.
Graham, A. P.
Gursoy, E. Y.
Hardie, G. H.
Haselow, J. R.
Hoggatt, J. E.
Kennedy, W. F.
Kirchgeorg, Clemens
McCutcheon, Malcolm
Pansch, F. N.
Petersen, G. W.
Potter, G. L.
Regan, D. M.
Ryan, D. J.
Schaefer, Frederick
Schrang, E. A.
Schwab, R. L.
Smith, F. H.
Springer, V. G.
Suechting, R. L.
Talbot, A. E.
Varberg, W. R.

Neillsville:
Comstock, Elizabeth
Gungor, B. O.
Manz, K. F.
Ozturk, C. H.
Rosekrans, M. C.
Rosekrans, Sarah D.
Thompson, T. N., Jr.

Nekoosa:
Pfeiffer, L. R.
Thompson, J. E.

New Berlin:
Bukosky, R. J.
Clark, R. A.
De Vault, M. L.
Komar, R. R.
Schofield, Raymond
Selle, F. S.
Varma, S. D.

New Franken:
Looze, J. A.

New Glarus:
Marty, P. H.

New Holstein:
Engel, A. C.
Larme, F. P.

New Lisbon:
Koch, C. B
Weston, C. L.

New London:
Dernbach, G. P.
Monsted, J. W.
Schmallenberg, H. C.
Weber, J. W.

New Richmond:
Armstrong, J. H.
Craig, J. L.
Davis, R. R.
Drury, E. M.
Epley, O. H.
Weisbrod, L. W.

Niagara:
Maginn, Richard J.
McCormack, E. A.

Norwalk:
Allen, J. S.

Oconomowoc:
Brown, J. F.
Claude, J. L.
Driscoll, L. J.
Eisenman, T. S.
Epperson, D. P.
Frank, E. B.
Goral, T. J.
James, W. D.
Lameka, Peter
Matt, J. R.
Miller, G. D.
Nammacher, T. H.
O'Hara, J. J.
Rogers, A. F.
Schroeder, T. A.
Schuele, D. T.
Schumacher, B. J.
Theobald, P. B.
Weir, E. F.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, P. M.

Oconto:
Heinen, R. D.
Honish, John S.
Rogers, R. J.
Zantow, F. E.

Oconto Falls:
Culver, J. R.
Siefert, C. E
Strebe, K. L.
Theisen, J. K.

Omro:
Peck, D. D.
Schoenbechler, L. J.

Oregon:
Dukerschein, F. N.
Johnson, E. S.
Kellogg, L. S.

Orfordville:
McNair, E. R.

Osceola:
Inyart, J. R.
Simenstad, J. O.
Simenstad, L. O.
Stone, R. H.

Oshkosh:
Apell, M. G.
Becker, D. B., Jr.
Behnke, C. H.
Bitter, R. H.
Bowerman, C. I
Clark, W. E.
Connell, F. G.
Cummings, E. F.
Danforth, H. J.
Enirich, P. S.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
Guenther, V. G.
Hahn, W. V.
Haines, M. C.
Hitselberger, J. F.
Hughes, J. B.
Isom, R. G.
Kivlin, T. M.
Koehler, A. G.
Kuhn, R. V.
Leibenson, S. J.
Leschke, John A.
Lyons, C. R.
McKenzie, J. R.
Meilicke, C. A.
Meli, J. V.
Monday, Harvey
Neubecker, R. D.
Payne, J. C.
Petersik, J. T.
Roberts, R. W.
Romberg, H. A.
Scheuermann, N. M.
Steen, M. H.
Stone, L. H.
Wagner, R. F.
Wagner, W. A.
Williams, E. B.
Winter, E. F.
Wolfgram, R. C
Wright, E. N.
Zmolek, E. J.

Osseo:
Garber, B. G.
Garber, R. E.
Knutson, Oscar
Leasum, R. N., Jr.

Owen:
Phillips, T. A.

Pardeeville:
Westcott, T. S.

Park Falls:
Enzinger, Josef
Eyvindsson, E. T.
Hanek, R. D.
Leahy, J. D.
Murphy, J. L.

Pell Lake:
Roenau, Elly A.

Peshtigo:
Barrette, Antoine

Phelps:
Wolcott, R. R.

Phillips:
Niebauer, W. E.
Rens, J. L.

Plain:
Galarnyk, I. A.

Platteville:
Andrew, C. H.
Gurkow, H. J.
Moffett, J. L.
Nuland, S. J.
Steidinger C. L.
Stuessy, M. F.

Plum City:
Docter, C. W.
Docter, J. C.

Plymouth:
Alvarez, R. J.
Brickbauer, A. J.
Dietsch, L. C.
Evers, R. H.
Steffan, L. J.
Weisse, H. A.

Portage:
Binnie, Helen A.
Bronson, F. H.
Cooney, R. T.
Grose, C. D.
Henney, C. W.
Henney, T. E.
Jones, W. W.
MacGregor, J. W.
Pavelsek, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.
Villavicencio, C. A.

Port Edwards:
Glenn, E. C.

Port Washington:
Bach, M. J
Barr, A. H.
Henkle, R. F.
Kauth, C. P.
Savage, G. F.

Wallestad, P. W.
Walsh, John F.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.

Prairie du Chien:
Dessloch, E. M.
Epley, V. C.
Farrell, T. F.
Garrity, M. S.
Love, R. G.
Satter, O. E.
Shapiro, H. L.
Wong, J. R.

Prairie du Sac:
Bishop, P. R.
Carlson, H. P.
Zauft, G. W.

Prentice:
Thomas, G. L.

Prescott:
Laney, H. J.

Princeton:
Mueller, G. G.

Pulaski:
Shippy, V. J.

Racine:
Ageloff, Harry
Albino, J. M.
Alexander, A. C.
Bacon, G. A.
Barina, H. J.
Baumblatt, D. P.
Baylon, V. A.
Bein, Robert
Bennett, W. H.
Bliwas, Arnold
Brewer, G. W.
Bruton, J. T.
Buckley, W. E.
Burch, V. J.
Burke, Donald
Christensen, F. C.
Christenson, C. W.
Coffey, B. T.
Constantine, C. E.
Cook, J. C.
Covell, K. W.
Currie, R. E
DeGroot, H. E.
Dorman, T. W.
Edwards, A. C.
Englander, S. M.
Faber, S. J.
Fazen, L. E., Jr.
Floch, L. J.
Fogle, R. J.
Foreman, J. W.
Fralich, J. C.
Gardetto, P. A.
Geenen, J. E.
Gehring, C. A.
Gerol, A. Y.
Gillett, G. N.
Goldstein, F. P
Graf, A. E.
Grant, A. B.
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Grinney, L. R.
Hammes, J. R.
Hemmingsen, T. C.
Henken, W. F.
Herrmann, A. A.
Hilker, H. C.
Hilpert, F. M.
Hogan, J. H.
Jacobsen, A. J.
Jamieson, J. G.
Kaarakka, O. F.
Kehl, K. C.
Keland, H. B
Kolmeier, K. H
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, L. J.
Lauerman, E. P.
Lehner, R. H.
Leitschuh, R. B.
Little, W. J., Jr.
MacVicar, E. L., Jr.
Maden, W. J.
Martinez, Enrique
Martinez, M. E.
Martinez-Larre, M.
Mayer, R. J.
McHale, J. A.
Miller, H. C.
Miller, P. L.
Miller, V. M.
Miller, W. C.
Minton, Richard
Nelson, M. W.
Newman, C. R.
Nickelsen, J. R.
Oberdorfer, C. E.
Olson, E. S.
Parker, M. G.
Patton, C. H.
Petersen, J. J. G.
Pinkus, W. H.
Pope, F. W.
Postorino, J. D
Rafiullah, Mahammed
Reyes, J. E.
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Schatz, W. R.
Scheible, F. J.
Scheller, R. F.
Schenkenberg, Grace E.
Schleper, A. J.
Schroeder, H. T.
Schuster, Myron
Shack, J. B.
Skow, G. D.
Skupniewicz, R. E.
Smith, L. W.
Smollen, W. J.
Smullen, G. H.
Steffen, Elizabeth A.
Stika, E. A.
Tomkiewicz, R. E.
von Jarchow, B. L.
Walters, H. G.
Williamson, W. H.

Randolph:
Horvath, D. C.

Random Lake:
Russell, J. A.

Reedsburg:
Ali, Masroor
Booher, J. A.
Hanko, J. E.
Knight, Robert G.
Pawlisch, O. V.
Rouse, J. J.
Simeon, R. G.
Stadel, E. V.

Rhinelander:
Brown, J. F.
Bump, W. S.
Cline, Frances A.
Eggman, L. D.
Haug, Thomas M.
Johnson, A. G.
Litton, E. W.
Litton, M. A.
Mescher, T. J.
Nevin, Ismail Nik
Osborne, R. R.
Pratt, G. F.
Rosemeyer, O. G.
Schiek, I. E.
Simmons, W. K.
Thuerer, G. R.
Wright, Marvin

Rice Lake:
Cotts, L. R.
Eidsmoe, N. A.
Gillespie, M. E.
Henningsen, John
Hoyer, J. K.
Kristensen, L. A.
Kundel, R. R.
Maser, J. F.
Rydell, O. E.
Rydell, W. B.

Richfield:
Zintek, A. R.

Richland Center:
Edwards, R. W.
Edwards, W. C.
Glise, Roy C., Jr.
Housner, R. E.
Kelertas, J. H.
Meyer, K. H.
Parke, George, Jr.
Pippin, L. M.
Spear, Jack
Taft, D. J.
Tydrich, J. J.

Ripon:
Bachus, A. C.
Dittmer, O. A.
Johnson, J. M.
Lofdahl, S., Jr.
Pelton, R. S.
Schuler, W. H.

River Falls:
Dohnalek, D. W.
Grassl, F. O.
Hammer, R. M.
Haskins, P. S.
Orlow, W. O.

Rosholt:
Benn, V. A.

St. Croix Falls:
Ericksen, D. M.
Koepke, G. H.
Lagus, R. T.
Nelson, L. K.
Olson, L. L.
Peterson, E. H
Riegel, F. B.
Riegel, J. A.
Wegner, M. E.

St. Nnzianz:
Foley, M. E.

Sauk City:
Bachhuber, H. A.
Kraus, E. T. F.
Walsh, T. W.

Schofield:
Olson, M. H.
Pellicer, J. G.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sieb, L. H.

Sharon:
Schrock J. B., Jr.

Shawano:
Albright, J. J.
Arvold, D. S.
Bergmann, F. T.
Cantwell, A. A.
Cantwell, R. C.
Coan, W. A.
Jeffries, Donald A.
Logemann, R. L.
Schulz, D. W.
Sealby, R. L.
Sebesta, A. J

Sheboygan:
Ashby, A. O.
Bassewitz, P. P.
Batzner, D. J.
Braun, N. P.
Bringe, J. W.
Cinelis, Ann A.
Dick, H. J.
Eckardt, B. F.
Graf, C. A.
Gruenewald, Ludwig
Heinz, H. N.
Hidde, F. G.
Hildebrand, G. J.
Hildebrand, J. F.
Hoon, J. R.
Houfek, E. E.
Huibregtse, W. G.
Jaeck, J. L.
Jochimsen, E. H.
Johnson, R. C.
Jumes, M. G.
Keller, R. A.
Kovacic, J. F.
Malewiski, L. J.
Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Michael, J. D.
Moir, Jane M.
Moir, W. W.
Mooney, F. L.
Mueller, H. A.
Nause, F. A.
Nause, F. P.
O'Donnell, S. P.
Pauly, L. F.
Pauly, R. C.
Pointer, R. W.
Quinn, G. A.
Rammer, M. A., Jr.
Reinemann, J. M.
Schott, E. G.
Schroeder, I. L.
Sciarra, P. A.
Senty, R. M.
Simonson, L. M.
Simpson, R. M.
Stewart, O. K.
Tasche, J. A.
Tasche, L. W.
Tompsett, A. C., Jr.
Van Driest, J. J.
Weber, C. J.
Windsor, R. B.
Winsauer, H. J.
Wood, R. A.

Sheboygan Falls:
Hansen, H. J.
Leighton, F A.
Weygandt, J. L.

Shell Lake:
Flogstad, Duane
Moen, D. V.
Welter, D. J.

Shiocton:
La Croix, G. M.

Shorewood:
Vlazny, F. J.

Shullsburg:
Hoesley, H. F.

Silver Lake:
De Witt, C. A.

Siren:
Sun, K. C.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

South Milwaukee:
Adali, I. S.
Crigler, R. R.
Flanerty, G. S.
Grimm, J. J.
Leite, Joaquim
McFadden, Wayne
Murphy, G. V.
O'Leary, W. J.
Pizer, J. A.
Roob, D. M.
Schwartz H M.
Spencer, G. N.
Theisen, C. E.
Turgal, Valerio
Zahl, W. H.

Sparta:
Albrecht, P. G.
Beebe, D. C.
Brown, J. D.
Harris, A. J.
Lukasek, E. O.
Najafzadeh, Moktar
Williams, H. H., Jr.

Spooner:
Goetsch, F. H.
Matzke, R. W.
Olson, L. J.

Spring Green:
Kempthorne, G. C.

Spring Valley:
Meyer, R. J

Stanley:
La Breche, J. J.
Mathwig, R. J.
Overgard, A. W.
Sallis, D. A.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Bickford, R. H.
Bosworth, W. C.
Dunn, A. G.
Eckberg, R. A.
Erickson, J. R.
Gehin, F. E.
Gramowski, W. A.
Hacker, P. K.
Iber, F. C.
Kennedy, J. T.
Kohn, A. M.
Milano, Angelo
Miller, S. R.
Reichardt, F. W.
Rice, M. G.
Rifleman, R. H.
Riordan, J. F.
Schierl, A. G.
Sciarrone, Francesco
Sevenich, J. R.
Sheehan, W. C.
Slater, R. H.
Sowka, A. J.
Sowka, P. N.

Stockbridge:
Knauf, J. A.

Stone Lake:
Marlewski, C. R.

Stoughton:
Hermundstad, O. A.
Nelson, D. L.
Nordholm, V. W.
Peterson, R. K.
Schammel, F. M.
Schoenbeck, P. J.
Schoenbeck, R. F.

Stratford:
Kroeplin, F. C.

Sturgeon Bay:
Beck, J. G.
Brook, J. J., Jr.
Evenson, R. G.
Grota, H. D.
Hobson, W. S.
Sheets, W. G.
Wagener, N. R.

Sun Prairie:
Behrend, J. F.
Green, R. E.
Hahn, M. F.
Nelson, E. J.
Russell, W. T.
Syty, Joseph

Superior:
Anderson, R. T.
Doyle, T. J.
Ekblad, V. E.
Finn, Milton
Fruehauf, R. P.
Giesen, Conrad W.
Johnson, F. G., Jr.
Knights, J. A.
Krahl, Enzo
Lavine, I. H.
Lavine, M. M.
Mann, Robert
Mataczynski, R. R.
McGill, J. W.
McGinnis, J. P.
Picard, C. J.
Rosin, L. R.
Scott, C. M.
Sellers, R. L.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T.

Sussex:
Van Valin, E. C.

Theresa:
Langenfeld, G. P.

Thiensville:
Elbe, T. D.
Herman, Murray
Kim, K. S.
Levy, E. S.

Thorp:
Connolly, James
Neis, F. P.

Tigerton:
Helse, L. F.

Tomah:
Konicek, R. G.
Kozarek, C. E.
Landmann, G. A.
Mubarak, J. S.
Ryan, C. J.

Tomahawk:
Baker, R. G.
Bugarin, N. L.
Francisco, Orlando
Henderson, R. J.
Jarvis, D. F.

Turtle Lake:
Halberg, A. C.

Twin Lakes:
Slocumb, C. O.

Two Rivers:
Kaner, S. L.
Kozelka, A. W.
Kuljis, D. A.
Martin, R. E.
Mir, A. A.
Myers, R. E.
Weld, S. L.
Zlatnik, A. P.
Zlatnik, P. A.

Union Grove:
Esener, Ismail
Haedike, W. D.
Lawrence, P. J.
Schulz, G. J.
White, E. F.

Valders:
Thranow, J. A., Jr.

Verona:
Davis, J. B.
Pellett, J. R.
Stuesser, G. J.

Viroqua:
Ender, C. A.
Gulbrandsen, L. F.
Kuehn, A. E.
Oppert, H. E.
Starr, R. A.
Vig, D. E.
Vig, De Verne W.
Vig, E. N.

Wabeno:
Tenley, O. S.

Wales:
Francis, R. J.

Walworth:
Bingol, O. G.
Bruhn, I. J.
Coon, W. W.
Hansen, D. R.
Kroyer, T. J.

Washburn:
Telford, J. G.

Washington Island:
Rutledge, P. E.

Waterford:
Bardenwerper, H. W.
Dietz, R. J.

Waterloo:
Gagan, R. J.
Garman, J. S.

Watertown:
Baldwin, R. C.
Becker, J. H.
Burzynski, E. E.
Miller, E. A.
Nowack, L. W.
Reed, W. H.
Schuh, E. P.
Von Gradulewski, M. A.

Waukesha:
Alston, J. A.
Barber, J. L.
Bartos, J. A.
Bartos, R. E.
Bemman, K. C.
Bischel, J. R.
Bolger, James V., Jr.
Brown, W. E.
Buerger, E. J.
Buhl, J. L.
Bunke, J. W.
Burch, R. N.
Campbell, P. E.
Carroll, P. E.
Church, Ruth E.
Clothier, W. J. K., Jr.
Conklin, J. W.
Davies, E. B.
Davies, Gwilym
Desch, C. A.
Dugan, T. E.
Edmondson, C. C.
Edson, J. D.
Feulner, R. C.
Frantz, R. G.
Franzen, L. D.
Fruchtman, M. Z.
Gallo, G. L.
Gantz, H. A.
Gilbert, Francis
Guy, J. R.
Hillan, D. D.
Holzgrafe, R. E.
Kaschat, R. L.
Konetzki, W. H.
Kritter, A. E.
Leenhouts, K. C.
McCormick, G. L.
McDonell, T. H.
Mehr, M. P.
Merkow, William
Miller, O. E.
Monk, R. S.
Motzel, A. J., Jr.
Nachacel, D. P., Jr.
Nolan, J. L.
Peterson, J. A.
Promer, J. E.
Rasmussen, R. J.
Richter, A. M.
Schmidt, C. W.
Schulz, E. G.
Smirl, W. G.
Smith, W. D.
Sweed, Aaron
Sydow, H. F.
Thompson, F. A
Thorgersen, T. M.
Werra, B. J.
Werra, M. J.
Wood, C. A.
Zietlow, F. G.

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Marquis, W. R.

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Boudry, M. O.
Haman, K. L.
Salan, J. R.
Salan, Sam
Steiner, J. H.

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Camacho, E. M.
Chapman, M. J.
Hebenstreit, A. J.
Hull, H. H.
Hull, S. B.
Petters, W. J.
Pyle, R. L.
Reslock, C. P.
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Schrank, R. E.
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Backer, G. L.
Backer, W. D.
Balliet, C. M.
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Becker, W. T.
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Brister, G. H.
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Freeman, J. M.
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Hendrickson, W. O.
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Kramer, J. D.
Larsen, R. B.
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Ludwig, E. P.
Mallery, O. T.
Martens, J. H.
McCandless, E. E.
Miller, T. O.
Miller, W. C.
Molinaro, A. J.
Muehlenbeck, E. C.
Norton, W. I.
Peterson, T. H.
Prehn, F. C.
Rossman, L. J.
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Stahmer, K. H.
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Barta, E. F.
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Osgood, C. W.
Patterson, R. H.
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Propeck, S. L
Ricciardi, I. J.
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Schmidt, J. R.
Schulte, W. J.
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Stuhler, J. D.
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Couch, J. R.
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Frederick, R. H.
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Hermann, W. C.
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Miner, D. L.
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Smits, R. H.
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Stern, L. S.
Stern, R. S.
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Wilkinson, J. J.
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Ziebert, A. P.
Zimmer, J. F.
Zimmer, J. J.

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Frankow, R. O.
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Nielsen, W. A.
Scheunemann, W. E.
Sorensen, R. F.

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Zimmermann, T. A.

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Gutheil, D A.
Lenz, R. B.

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Lloyd, B. E.
Morris, D. L.
Swarthout, Edyth C.

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Demke, R. L

Weyauwega:
Maasch, L. P.

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Lang, J. L.
Lang, G. E.

Whitehall:
Hanley, L. L.
Simons, N. S.

Whitewater:
Ambrose, S. H.

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Hadden, S. L.
Hong, Roy
Kjentvet, R. A.
Wichmann, R. D.

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Wiswell, C. Y.

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Cook, H. E.

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Bobowski, C. D.
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Loftus, E. R.
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Morton, Silvanus A.
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----------Claremont, Calif.

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* Granted life membership in 1967.

Scientific Fellow

Berman, A. L., Ph.D. ----------Madison

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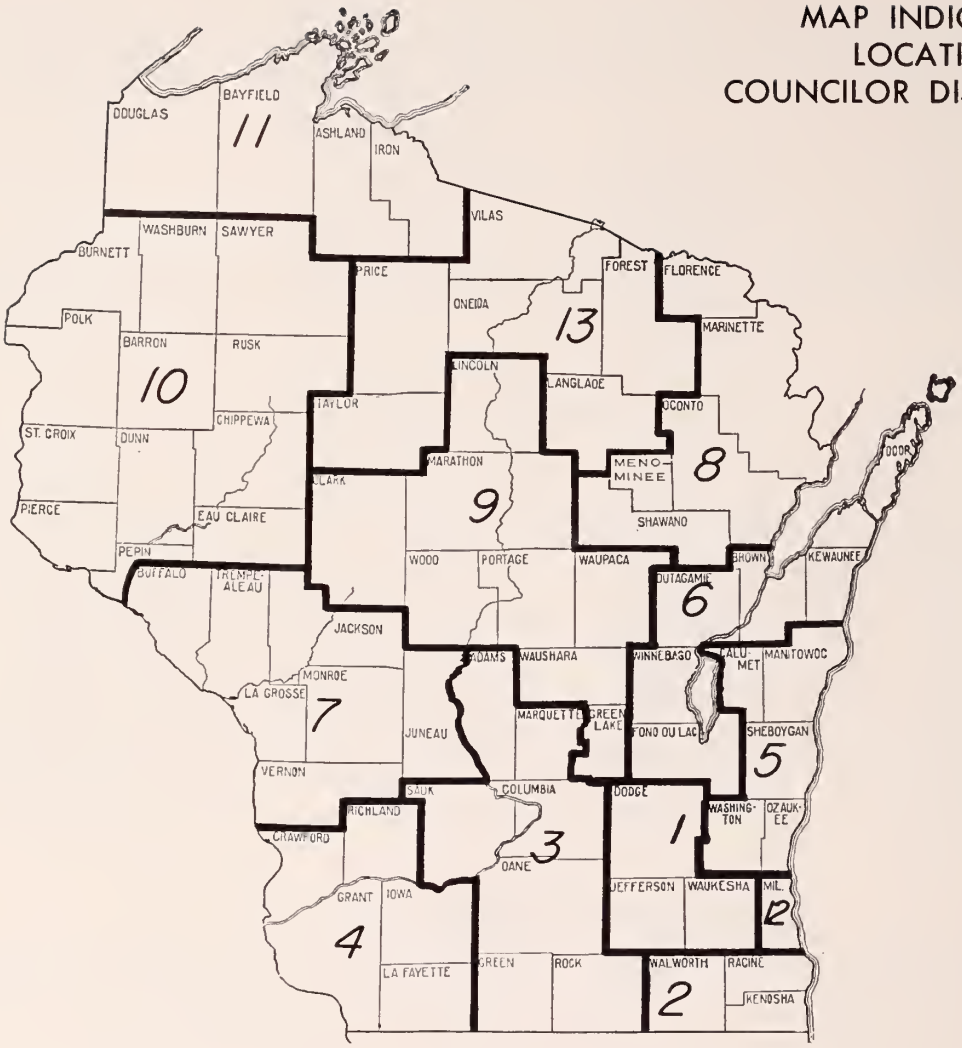

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M. F. Huth, MD, Baraboo
C. W. Stoops, MD, Madison

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H. W. Carey, MD, Lancaster

FIFTH DISTRICT:
Jerry W. McRoberts, MD, Sheboygan

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John E. Dettmann, MD, Green Bay
James A. Sisk, MD, Fond du Lac

SEVENTH DISTRICT:
J. C. Fox, MD, La Crosse

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J. W. Boren, Jr., MD, Marinette

NINTH DISTRICT:
E. P. Ludwig, MD, Wausau

TENTH DISTRICT:
W. R. Manz, MD, Eau Claire

ELEVENTH DISTRICT:
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W. J. Houghton, MD, Milwaukee
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S. L. Chojnacki, MD, Milwaukee
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Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk, and Rusk County Societies. **W. R. Manz, MD** (1965–1968), 204 East Grand Ave., Eau Claire 54701.

Eleventh: Ashland–Bayfield–Iron, and Douglas County Societies. **C. A. Grand, MD** (1966–1969), Masonic Temple Bldg., Ashland 54806.

Twelfth: The Medical Society of Milwaukee County. **L. J. Van Hecke, MD** (1966–1969), 6001 West Center St., Milwaukee 53203; **W. J. Houghton, MD** (1966–1969), 2943 North Oakland Ave., Milwaukee 53211; **W. J. Egan, MD** (1967–1970), 525 East Wells St., Milwaukee 53202; **S. L. Chojnacki, MD** (1965–1968), 3122 South Thirteenth St., Milwaukee 53215; **S. W. Hollenbeck, MD** (1965–1968), 2650 West Fond du Lac Ave., Milwaukee 53206; **J. M. Sullivan, MD** (1967–1970), 161 West Wisconsin Ave., Milwaukee 53203.

Thirteenth: Forest, Langlade, Oneida–Vilas, and Price–Taylor County Societies. **Marvin Wright, MD** (1965–1968).

PAST PRESIDENT (1967–1968).....**F. E. Drew, MD**
425 East Wisconsin Ave., Milwaukee 53202

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

W. B. Hildebrand, MD (1967–1969), 59 Racine St., Menasha 54952.

R. E. Galasinski, MD (1967–1969), 3333 South 27th St., Milwaukee 53215.

J. M. Bell, MD (1966–1968), 516 Houston St., Marinette 54143.

E. L. Bernhart, MD (1966–1968), 2714 West Burleigh St., Milwaukee 53210.

Alternates

N. A. Hill, MD (1967–1969), 304 West Washington Ave., Madison 53703.

G. E. Collentine, Jr., MD (1967–1969), 2266 North Prospect Ave., Milwaukee 53202.

J. C. Fox, MD (1966–1968), 212 South Eleventh St., La Crosse 54601.

C. J. Picard, MD (1966–1968), 425 Twenty-first Ave. East, Superior 54880.

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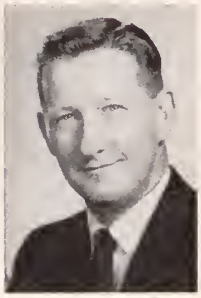
* Map indicating location of councilor districts, page 88.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May. Dates in parentheses indicate beginning and expiration of term of office.

Standing Committees—1967-1968

State Medical Society of Wisconsin



COMMITTEE ON CANCER

(Composed of a member from each Councilor District)

G. A. Smiley, MD
Chairman

G. A. Smiley, MD (1965–1968) ..... Delavan 53115
Chairman 102 North Third St.

Helen J. Gurkow, MD (1967–1968) ... Platteville 53818
195 East Main St.

J. K. Scott, MD (1967–1970) ..... Madison 53711
1605 Monroe St.

G. H. Williams, MD (1967–1970) .... ..Marshfield 54449
650 South Central Ave.

G. I. Uhrich, MD (1965–1968) ..... La Crosse 54601
212 South Eleventh St.

R. C. Frank, MD (1965–1968) ..... Eau Claire 54701
Sacred Heart Hospital

J. J. Gramling, Jr., MD (1965–1968) ... Milwaukee 53202
10425 West North Ave.

J. F. Brown, MD (1965–1968) ..... Rhinelander 54501
1020 Kabel Ave.

J. R. Hoon, MD (1966–1969) ..... Sheboygan 53081
1011 North 8th St.

G. Daniel Miller, MD (1966–1969) .. Oconomowoc 53066
37880 Forrest Dr.

F. L. Schaefer, MD (1966–1969) ..... Menasha 54952
59 Racine St.

Enzo Krahl, MD (1966–1969) ..... Superior 54880
3600 Tower Ave.

D. A. Jeffries, MD (1967–1970) ..... Shawano
Cantwell–Peterson Clinic

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Chairman 324 East Wisconsin Ave.

J. D. Leahy, MD (1966–1969) ..... Park Falls 54552
Vice-chairman 170 Fourth Ave. North

C. E. Wall, MD (1967–1970) ..... Manitowoc 54220
904A South Eighth St.

O. G. Moland, MD (1967–1970) ..... Augusta 54722

E. D. Sorenson, MD (1965–1968) ..... Elkhorn 53121
104 South Wisconsin St.

R. W. Mason, MD (1965–1968) ..... Marshfield 54449
650 South Central Ave.

D. R. Griffith (1966–1969) ..... Eau Claire 54701
314 Grand Ave. East

M. F. Huth, MD (1966–1969) ..... Baraboo 53913
203 Fourth St.

O. E. Larson, MD (1967–1970) ..... Menasha
422 Broad St.

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(Formerly Public Relations and Communications)

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J. S. Devitt, MD (1967–1970) ..... Milwaukee 53202
Chairman 2243 North Prospect Ave.

C. A. Olson, MD (1967–1970) ..... Baldwin 54002

C. J. Picard, MD (1965–1968) ....Superior 54880
425—21st Ave. East

R. G. Hansel, MD (1965–1968) ..... Baraboo 53913
407 Oak St.

R. R. Rueckert, MD (1965–1968) ..... Portage 53901
143 East Cook St.

R. B. Bourne, MD (1966–1969) ..... Milwaukee 53202
208 East Wisconsin Ave.

W. E. Myers, MD (1967–1969) ..... Fond du Lac
505 East Division St.

G. W. Dean, MD (1967–1969) ..... Milwaukee
425 East Wisconsin Ave.

P. E. Wainscott, MD (1967–1970) ..... Menasha
422 Broad St.

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W. T. Russell, MD (1966–1971) ..... Sun Prairie 53590
Chairman 215 East Main St.

C. F. Broderick, MD (1963–1968) .. Wisconsin Dells 53965
Vice-chairman Box 325

E. C. Quackenbush, MD (1967–1972) .... Hartford 53027
14 North Main St.

L. W. Schrank, MD (1967–1972) .....Waupun 53963
600 Fern St.

T. E. Henney, MD (1967–1972) ..... Portage 53901
310 West Conant St.

J. M. Lubitz, MD (1964–1969) ..... Brookfield 53005
1950 Alverno Dr.

L. J. Kurten, MD (1965–1970) ..... Racine 53404
2405 Northwestern Ave.

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Anesthesiology 1300 University Ave.

H. A. Peters, MD (1967–1970) ..... Madison 53706
Neurology & Psychiatry 1300 University Ave.

J. V. Bolger, Jr., MD (1967–1970) ..... Waukesha 53186
Ophthalmology 102 East Main St.

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Otolaryngology 1011 North Eighth St.

J. R. Schroder, MD (1967–1970) ..... Janesville 53545
Pediatrics 1344 Creston Park Dr.

R. L. Gilbert, MD (1965–1968) ..... La Crosse 54601
Internal Medicine 1707 Main St.

J. B. Durst, MD (1965–1968) ..... La Crosse 54601
Obstetrics & Gynecology 1707 Main St.

P. K. Odland, MD (1965–1968) ..... Janesville 53545
Orthopedics 305 Court St.

S. A. Freitag, MD (1965–1968) ..... Janesville 53545
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A. D. Anderson, MD (1965–1968) ..... Madison 53703
Surgery 2 West Gorham St.

J. L. Teresi, MD (1966–1969) ..... Brookfield 53005
Pathology 14760 Virginia

Lyle Edelblute, MD (1966–1969) ..... Green Bay 54301
Radiology Bellin Memorial Hospital

Donald S. Schuster, MD (1966–1969) .... Madison 53705
Dermatology 222 North Midvale Blvd.

N. G. Bauch, MD (1966–1969) ..... Milwaukee 53222
General Practice 3102 North 78th St.

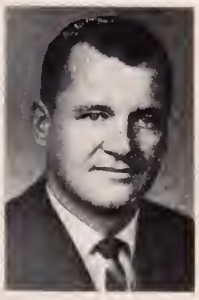
J. A. Van Susteren, MD (1966–1969) .... La Crosse 54601
Public Health 250 Mormon Coulee Rd.

J. F. Morrissey, MD (1967–1970) ..... Madison 53706
Medical Faculties 1300 University Ave.

President Kief, *ex officio*

President-elect James, *ex officio*

Secretary Crownhart, *ex officio*



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T. V. Geppert, MD (1963–1968) ..... Madison 53715
Chairman 1313 Fish Hatchery Rd.

O. O. Meyer, MD (1963–1968) ..... Madison 53706
1300 University Ave.

E. S. Gordon, MD (1964–1969) ..... Madison 53706
1300 University Ave.

A. G. Martin, MD (1964–1969) ..... Milwaukee 53202
324 East Wisconsin Ave.

J. A. Killins, MD (1965–1970) ..... Green Bay 54303
123 North Military Ave.

R. A. Starr, MD (1965–1970) ..... Viroqua 54665
318 South Main St.

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545 North 15th St.

B. R. Lawton, MD (1966–1971) ..... Marshfield 54449
650 South Central Ave.

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5001 Monona Dr.

E. R. Daniels, MD (1967–1972) ..... Wauwatosa 53213
7400 Harwood Ave.

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Ex officio 5 West Rollin St.

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Ex officio 561 North 15th St.

P. L. Eichman, MD, Dean, University of Wisconsin Medical School ..... Madison 53706
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Chairman

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G. W. Hilliard, MD (1967–1970) ..... Milwaukee 53212
435 West North Ave.

R. S. Galgano, MD (1965–1968) ..... Delavan 53115
610 Walworth Ave.

L. W. Schrank, MD (1967–1968) ..... Waupun 53963
600 Fern St.

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20 South Park St.

S. L. Henke, MD (1966–1969) ..... Eau Claire 54701
314 Grand Ave. East

P. C. Dietz, MD (1966–1969) ..... La Crosse 54601
1020 Market St.

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324 East Wisconsin Ave.

P. L. Eichman, MD, Dean, University of Wisconsin Medical School ..... Madison 53706
Ex officio 1300 University Ave.

G. A. Kerrigan, MD, Dean, Marquette School of Medicine, Inc. ..... Milwaukee 53233
Ex officio 561 North Fifteenth St.

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Chairman of the Council, Chairman

Immediate Past President

President

President-elect

Secretary

COUNCIL COMMITTEES

Appointments to the following committees are made by the chairman of the Council at the time of the Annual Meeting in May.

Committees of the Council (composed of members of Council):

Economic Medicine
Executive
Finances
Planning
Scientific Medicine

Council Committees:

Ad Hoc: The Medical Practice Act
Disaster Medical Care
Commission on Medical Care Plans
Commission on Safe Transportation
Commission on State Departments
Editorial Board
Military Medical Service
Past Presidents

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(Appointed by the Chairman of the Council and composed of members of the Council)

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Chairman of the Council 212 South 11th St.
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Vice-chairman of the Council
Chairman, Finances 2715 Marshall Ct.
W. R. Manz, MD ..... Eau Claire 54701
Chairman, Planning ..... 204 E. Grand Ave.
L. J. Van Hecke, MD ..... Milwaukee 53210
Chairman, Scientific Medicine 6001 West Center St.
G. J. Schulz, MD ..... Union Grove 53182
Chairman, Economic Medicine ..... 722—15th Ave.
H. J. Kief, MD, president ..... Fond du Lac 54935
Chairman 505 East Division St.
Ex officio
W. D. James, MD, president-elect .. Oconomowoc 53066
Ex officio 340 Summit Ave.
F. E. Drew, MD, past president ..... Milwaukee 53202
Ex officio 425 East Wisconsin Ave.

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Chairman 6001 West Center St.
J. W. McRoberts, MD ..... Sheboygan 53081
1011 North 8th St.
C. W. Stoops, MD ..... Madison 53703
110 East Main St.
W. J. Houghton, MD ..... Milwaukee 53211
2943 North Oakland Ave.
S. W. Hollenbeck, MD ..... Milwaukee 53206
2650 West Fond du Lac Ave.
J. C. Fox, MD ..... La Crosse 54601
Chairman of the Council
Ex officio 212 South 11th St.

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Chairman 722 15th Ave.
J. M. Sullivan, MD ..... Milwaukee 53203
161 West Wisconsin Ave.
Marvin Wright, MD ..... Rhinelander 54501
1020 Kabel Ave.
J. A. Sisk, MD ..... Fond du Lac 54935
566 Fifth St.
H. W. Carey, MD ..... Lancaster 53813
257 Madison St.
J. C. Fox, MD ..... La Crosse 54601
Chairman of the Council
Ex officio 212 South 11th St.

PLANNING

W. R. Manz, MD ..... Eau Claire 54701
204 E. Grand Ave.
M. F. Huth, MD ..... Baraboo 53913
203 Fourth St.
C. A. Grand, MD ..... Ashland 54806
Masonic Temple Building
W. J. Egan, MD ..... Milwaukee 53202
720 North Jefferson St.
E. P. Ludwig MD ..... Wausau 54401
400 Strollers Lane
J. C. Fox, MD ..... La Crosse 54601
Chairman of the Council
Ex officio 212 South 11th St.

FINANCES

E. J. Nordby, MD (1967–1969) ..... Madison 53705
Chairman 2715 Marshall Ct.
Marvin Wright, MD (1967–1970) .... Rhinelander 54501
1020 Kabel Ave.
J. W. Boren, Jr. MD (1965–1968) ..... Marinette 54143
1510 Main St.
S. L. Chojnacki, MD (1965–1968) .... Milwaukee 53215
3122 South 13th St.
H. G. Bayley, MD (1967–1970) ..... Beaver Dam 53916
138 Front St.
J. E. Dettmann, MD (1966–1969) .... Green Bay 54301
519 South Monroe Ave.
J. A. Sisk, MD (pro tem) ..... Fond du Lac 54935
566 Fifth St.
W. J. Egan, MD (pro tem) ..... Milwaukee 53202
525 E. Wells St.
F. L. Weston, MD, treasurer ..... Madison 53704
Ex officio 1659 Sherman Ave.
J. C. Fox, MD ..... La Crosse 54601
Chairman of the Council
Ex officio 212 South 11th St.

SMS COUNCIL COMMITTEES 1967–1968

(Appointed by the Chairman of the Council and composed of members of the State Medical Society)

DISASTER MEDICAL CARE

J. S. Wier, MD ..... Fond du Lac 54935
Chairman 80 Sheboygan St.
E. A. Bachhuber, MD ..... Milwaukee 53226
8700 West Wisconsin Ave.
S. J. Graiewski, MD ..... Oshkosh 54901
155 North Sawyer
D. L. Williams, MD ..... Madison 53703
30 South Henry St.
Harold Cook, MD ..... Wind Lake 53185
12325 Fries Lane
E. P. Rohde, MD ..... Galesville 54630

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(Advisory to Medical Editor, *Wisconsin Medical Journal*)

D. W. Ovitt, MD ..... Milwaukee 53202
2266 North Prospect Ave.
M. F. Huth, MD ..... Baraboo 53913
203 Fourth St.
L. G. Kindschi, MD ..... Monroe 53566
1770 13th St.
G. A. Cooper, MD ..... Madison 53703
110 E. Main St.
M. C. F. Lindert, MD ..... Milwaukee 53213
6745 West Wells St.
V. S. Falk, MD, Medical Editor ..... Edgerton 53534
Chairman 5 West Rollin St.
Ex officio

MILITARY MEDICAL SERVICE

F. L. Weston, MD ..... Madison 53704
Chairman 1659 Sherman Ave.
J. M. Sullivan, MD ..... Milwaukee 53203
161 West Wisconsin Ave.
M. H. Steen, MD ..... Oshkosh 54901
421 Jefferson St.
O. G. Moland, MD ..... Augusta 54722
D. S. Arvold, MD ..... Shawano 54166
117 East Green Bay St.

COMMISSION ON MEDICAL CARE PLANS

E. M. Dessloch, MD (1967–1970) .. Prairie du Chien 53821
Chairman Medical Park
Robert Krohn, MD (1965–1968) .. Black River Falls 54615
Vice-chairman Krohn Clinic
G. W. Carlson, MD (1967–1970) ..... Appleton 54911
103 West College Ave.
D. N. Goldstein, MD (1967–1970) ..... Kenosha 53141
Box 743
A. W. Hilker, MD (1967–1970) ..... Eau Claire 54701
314 Grand Avenue East
P. B. Mason, MD (1967–1970) ..... Sheboygan 53081
1011 North 8th St.
E. J. Nordby, MD (1967–1970) ..... Madison 53705
2715 Marshall Ct.
L. O. Simenstad, MD (1967–1970) ..... Osceola 54020
195 Hammond St.
A. H. Stahmer, MD (1967–1970) ..... Wausau 54401
404 South Third Ave.
Howard Mauthe, MD (1967–1970) .. Fond du Lac 54935
74 South Reserve Ave.
W. T. Casper, MD (1965–1968) ..... Milwaukee 53216
4222 West Capitol Dr.
A. J. McCarey, MD (1965–1968) ..... Green Bay 54301
1114 Emilie
J. T. Sprague, MD (1965–1968) ..... Madison 53703
109 East Johnson St.
F. H. Wolf, MD (1965–1968) ..... La Crosse 54601
Box 908
Milton Finn, MD (1966–1969) ..... Superior 54880
3600 Tower Ave.
D. A. Jeffries, MD (1966–1969) ..... Shawano 54166
117 East Green Bay St.
Charles Benkendorf, MD (1966–1969) .. Green Bay 54301
408 St. Francis Drive
T. J. Doyle, MD (1966–1969) ..... Superior 54880
1507 Tower Ave.
J. H. Houghton, MD (1966–1969) .. Wisconsin Dells 53965
Box 325
R. A. Sievert, MD (1966–1969) ..... Madison 53715
925 Mound St.
W. E. Wright, MD (1966–1969) ..... Mondovi 54755
221 North Eau Claire St.

President Kiel
President-elect James

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Chairman 16 North Carroll St.
W. J. Egan, MD ..... Milwaukee 53202
Vice-chairman 525 East Wells St.

Division Chairmen:

J. J. Suits, MD ..... Marshfield 54449
Handicapped Children 650 South Central Ave.
G. G. Stebbins ..... Madison 53703
Aging 126 East Main St.
D. A. Treffert, MD ..... Winnebago 54985
Alcoholism–Addiction Winnebago State Hospital
John Evrard, MD ..... Milwaukee 53202
Maternal & Child Welfare 208 East Wisconsin Ave.
A. A. Lorenz, MD ..... Eau Claire 54701
Nervous & Mental Diseases 605 Walker Ave.
H. A. Anderson, MD ..... Stevens Point 54481
Chest Diseases River Pines Sanatorium
J. C. H. Russell, MD ..... Fort Atkinson 53538
School Health 38 South Water St.
Meyer S. Fox, MD ..... Milwaukee 53233
Ear, Nose & Throat 2040 West Wisconsin Ave.
Paul Dudenhoefer, MD ..... Elm Grove 53122
Rehabilitation 12535 Stephen Place
J. V. Bolger, MD ..... Waukesha 53186
Vision 102 East Main St.

PAST PRESIDENTS

F. E. Drew, MD ..... Milwaukee 53202
Chairman 425 East Wisconsin Ave.
J. H. Houghton, MD ..... Wisconsin Dells 53965
Box 325
W. P. Curran, MD ..... Antigo 54409
Box 420
W. J. Egan, MD ..... Milwaukee 53202
525 East Wells St.
M. A. McGarty, MD ..... La Crosse 54601
509 State Bank Building
R. P. Sproule, MD ..... Milwaukee 53202
1024 East State St.

Gunnar Gundersen, MD ..... La Crosse 54601
1836 South Ave.
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Two Thorstrand Rd.
K. H. Doege, MD ..... Marshfield 54449
650 South Central Ave.
J. C. Griffith, MD ..... Milwaukee 53202
2243 North Prospect Ave.
H. Kent Tenney, MD ..... Madison 53703
1155 Farwell Dr.
A. J. McCarey, MD ..... Green Bay 54301
1114 Emilie
E. L. Bernhart, MD ..... Milwaukee 53210
2714 West Burleigh St.
L. O. Simenstad, MD ..... Osceola 54020
195 Hammond St.
H. E. Kasten, MD ..... Beloit 53511
419 Pleasant St.
W. B. Hildebrand, MD ..... Menasha 54952
59 Racine St.
E. D. Sorenson, MD ..... Elkhorn 53121
104 South Wisconsin St.
L. H. Lokvam, MD ..... Kenosha 53140
723—58th St.
N. A. Hill, MD ..... Madison 53703
304 West Washington Ave.

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W. T. Russell, MD ..... Sun Prairie 53590
Chairman 215 East Main St.
H. G. Bayley, MD ..... Beaver Dam 53916
138 Front St.
J. D. Brown, MD ..... Sparta 54656
B. J. Mansheim, MD ..... La Crosse 54601
212 South 11th St.
C. A. Olson, MD ..... Baldwin 54002

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Chairman 716 Monroe St.
E. E. Eckstam, MD ..... Monroe 53566
R. F. Hudson, MD ..... Eau Claire 54701
715 South Barstow St.
Frederick Bunkfeldt, Jr., MD ..... Milwaukee 53202
525 East Wells St.
W. F. Smejkal, MD ..... Manitowoc 54220
R. C. Wixson, MD ..... Madison 53715
20 South Park St.
A. W. Wittchow, MD ..... Wisconsin Rapids 54494
710 East Grand Ave.
F. L. Rundle, MD ..... Madison 53715
20 South Park St.
G. C. Hillery, MD ..... Lancaster 53813
235 North Madison St.

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Secretary ..... Ruth A. Stoerker, Madison
Delegate ..... Sheldon Burchman, Milwaukee
Alternate ..... John W. Temple, Milwaukee

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Chairman ..... James W. Bringe, Sheboygan
Secretary ..... Robert Pittelkow, Milwaukee
Delegate ..... Garrett A. Cooper, Madison
Alternate ..... Morris A. Meister, Milwaukee

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Chairman ..... Norbert S. Bauch, Milwaukee
Secretary ..... Donald Heyrman, Menomonee Falls
Delegate ..... R. R. Richards, Eau Claire
Alternate ..... Eugene Kay, Milwaukee

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Chairman ..... Edward K. Ryder, Jr., Madison
Secretary ..... A. C. Costello, Milwaukee
Delegate ..... John M. Irvin, Monroe
Alternate ..... James A. Means, Milwaukee

SECTION ON MEDICAL FACULTIES

Delegate ..... O. O. Meyer, Madison
Alternate ..... E. A. Bachhuber, Milwaukee

SECTION ON NEUROLOGY AND PSYCHIATRY

Chairman ..... Leigh M. Roberts, Madison
Secretary ..... Herman Gladstone, Madison
Delegate ..... Joseph G. Brown, Madison
Alternate ..... Leigh M. Roberts, Madison

SECTION ON OBSTETRICS AND GYNECOLOGY

Chairman ..... Joseph Durst, La Crosse
Secretary ..... Richard Brown, Eau Claire
Delegate ..... William Madden, Racine
Alternate ..... Joseph Durst, La Crosse

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Chairman ..... J. V. Bolger, Jr., Waukesha
Secretary ..... W. H. Bennett, Racine
Delegate ..... C. F. Schmidt, La Crosse
Alternate ..... W. C. Parks, Milwaukee

SECTION ON ORTHOPEDICS

Chairman ..... C. W. Christenson, Racine
Secretary ..... Marvin Nelson, Racine
Delegate ..... Peter Golden, Madison
Alternate ..... C. H. Hickey, Jr., Milwaukee

SECTION ON OTOLARYNGOLOGY

Chairman ..... John K. Scott, Madison
Secretary ..... H. E. Manhart, Madison
Delegate ..... W. B. Larkin, Eau Claire
Alternate ..... John K. Scott, Madison

SECTION ON PATHOLOGY

Chairman ..... Joseph L. Teresi, Brookfield
Secretary ..... D. J. Lafond, Milwaukee
Delegate ..... Robert A. Scheidt, Milwaukee
Alternate ..... Lars W. Kleppe, Beloit

SECTION ON PEDIATRICS

Chairman ..... Frank C. Stiles, Monroe
Secretary ..... Charles Geppert, Madison
Delegate ..... Richard L. Meyers, Green Bay
Alternate ..... J. R. Guy, Waukesha

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Chairman ..... Carl N. Neupert, Madison
Secretary ..... Josef Preizler, Madison
Delegate ..... Ruth E. Church, Waukesha
Alternate ..... George H. Handy, Madison

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Chairman ..... Charles Benkendorf, Green Bay
Secretary ..... Harold F. Ibach, Milwaukee
Delegate ..... Wayne M. Rounds, Madison
Alternate ..... Alan B. Fidler, Milwaukee

SECTION ON SURGERY

Chairman ..... Albert G. Martin, Milwaukee
Secretary ..... Wilson Weisel, Milwaukee
Delegate ..... James M. Sullivan, Milwaukee
Alternate ..... B. Jack Longley, Madison

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Chairman ..... John N. Richards, Kenosha
Secretary ..... John Wear, Jr., Madison
Delegate ..... Vacancy
Alternate ..... Vacancy

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Secretary—Jordan N. Fink, MD, (Oct. 1968), Milwaukee

WISCONSIN SOCIETY OF ANESTHESIOLOGISTS

President—Fred D. Cook, MD, (Oct. 1968), Green Bay
Secretary—Ruth A. Stoerker, MD, (Oct. 1968), Madison

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President—James W. Bringe, MD, (Oct. 1968), Sheboygan
Secretary—Robert Pittelkow, MD, (Oct. 1968), Milwaukee

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A. J. McDowell, M.D., Soldiers Grove†.....1930
Cornelius A. Harper, M.D., Madison.....1930–1931
Otho Fiedler, M.D., Sheboygan.....1931–1932
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William P. Curran, M.D., Antigo.....1964–1965
J. H. Houghton, M.D., Wisconsin Dells.....1965–1966
Frank E. Drew, M.D., Milwaukee.....1966–1967

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* *Died during term of office as president-elect.*

† *Resigned, because of health, prior to taking office.*

‡ *Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.*

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Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

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John J. McGovern, MD† 1931
Louis M. Jermain, MD† 1931
Edward Evans, MD† 1931
Mina B. Glasier, MD† 1932
Arthur W. Rogers, MD† 1934
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Olin West, MD† 1934
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Arthur J. Patek, MD† 1935
Joseph F. Smith, MD† 1937
Eben J. Carey, MD† 1938
William S. Middleton, MD 1938
Fred G. Johnson, MD† 1939
William D. Stovall, MD 1940
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William B. Walsh, MD 1967

* Centennial Award. † Deceased.
** 125th Anniversary Award.

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The President of the State Medical Society, with the unanimous approval of the Council, has the privilege of presenting a Presidential Citation to a non-physician who has made a significant contribution to medicine or public health.

Since the establishment of this citation in 1959, the following persons have been so recognized:

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Helen Crawford (Librarian, University of Wisconsin Medical School Library) 1962
The Rev. Edward J. O'Donnell, S. J. (Chancellor of Marquette University) 1963
Harvey Higley (Former Administrator of Veterans Affairs), Marinette 1965
Francis J. Wilcox (National Board Chairman, American Cancer Society, and Board of Directors, Wisconsin Division, ACS), Eau Claire 1966
Warren P. Knowles (Governor of the State of Wisconsin), Madison 1967

Find your future in the HEALTH FIELD

. . . a career guide

"Find your future in the health field," urges a brochure published by the Wisconsin Health Council, Inc. The brochure, developed with the assistance of the State Medical Society, contains information on 26 careers in health.

The publication is unique in its presentation. It is intended to supplement existing careers materials, and gives factual and statistical information on personal qualifications, educational requirements and opportunities, and employment possibilities in each of the fields. It places emphasis on Wisconsin.

Copies are distributed to guidance counselors in every Wisconsin school, and individual copies are available from the Wisconsin Health Council to youngsters interested in health careers.

Supplies are also available to physicians who participate in career days in their local schools; they may be obtained by writing the State Medical Society, Box 1109, Madison 53701.

The Wisconsin Health Council, which published the brochure, was formed in 1948 to stimulate citizen interest in public health in Wisconsin.

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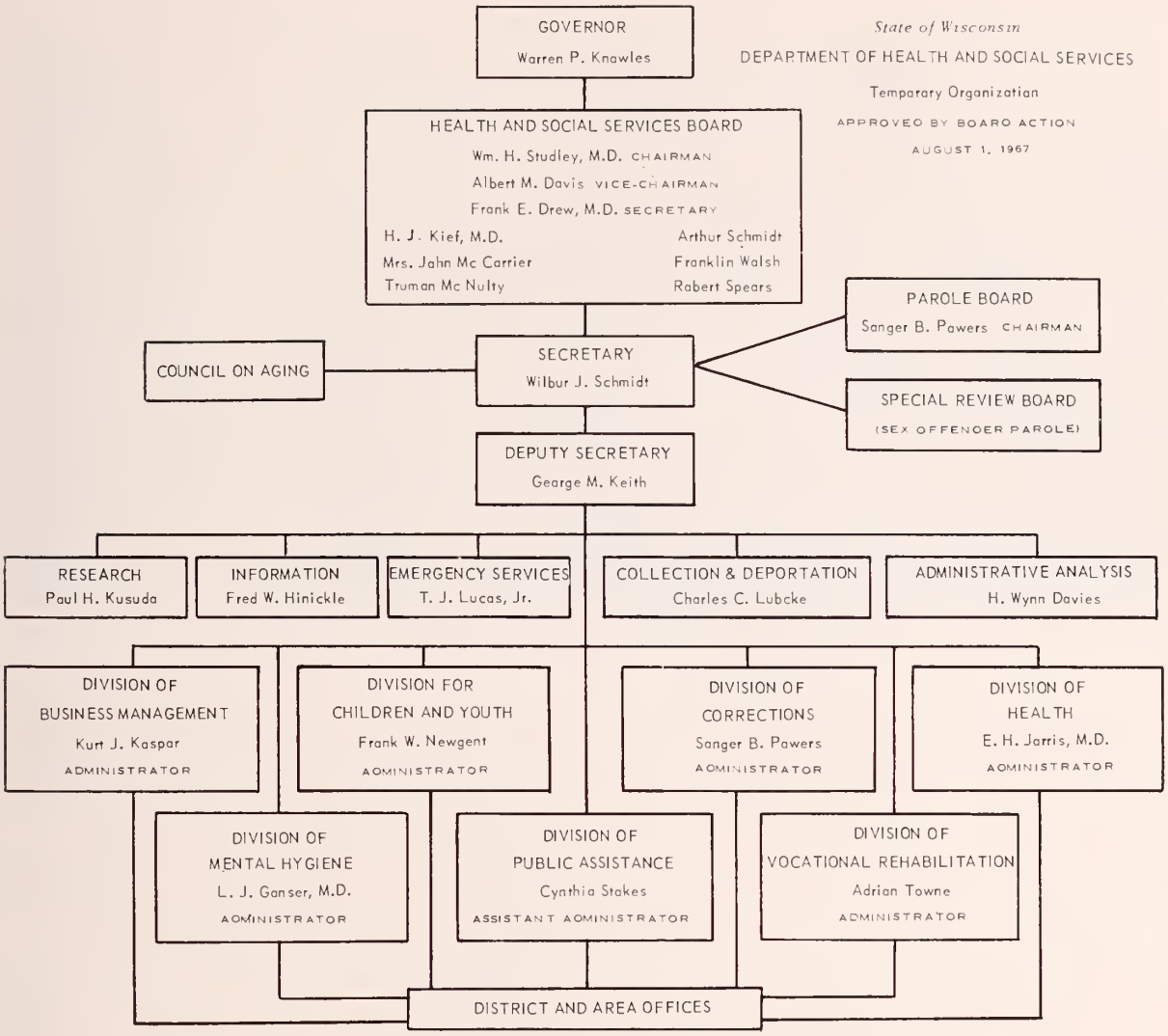

Department of Health and Social Services

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PLACEMENT SERVICE AIDS DOCTORS AND COMMUNITIES

Do you want an associate? Generalist or specialist? Then call 256–3101 or write Box 1109, Madison, Wisconsin 53701.

The Placement Service of the State Medical Society has helped many physicians find a new assistant, found promising locations for young practitioners, and brought resident medical service to many communities without a doctor.

Here is how the Placement Service may be able to help you. The Society maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Usually there are 30 to 50 generalists listed and a total of 80 to 125 specialists in all categories. The Society also maintains a list of physicians and communities offering opportunities to the physician in individual, group, and other types of practice. THE WISCONSIN MEDICAL JOURNAL offers a Physicians Exchange service each month at reasonable rates. Widows of deceased physicians who were members of the Society may use this service without charge.

Physicians who have used the Placement Service have described it as one of the most effective in the United States. JOURNAL advertising, too, has proved highly successful.

One word of advice: Advise the Society of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

THE PRESIDENT'S PAGE

HAROLD J. KIEF, M.D.

SMS means aggressive leadership

Our Aims Are Our Duties

"What are the aims which are at the same time duties?
They are the perfecting of ourselves, and the happiness of others."
—KANT

■ THE NEW YEAR of 1968 has begun. This year is new only in its number. The problems we had in 1967 have followed us into 1968, but with the continued help of the medical profession and our paramedical friends, we can take forward steps in solving the problems of "bettercare." Yes, bettercare to increase longevity, bettercare to reduce infant mortality, and bettercare to bring a superior quality of medicine to the people of our State.

This can be done if all of us keep in mind the 11-point statement of the "Purposes and Responsibilities of the American Medical Association." This statement was adopted by the House of Delegates meeting in Houston in November 1967. It is the most uptodate clarification of the role of the AMA since its founding in 1847. It makes clear our dedication to all our objectives and puts together incisively the challenges and duties that our profession recognizes. The House, in adopting the 11 points, noted that "it is the responsibility of the AMA, as the representative of the American medical profession to continue to foster the advancement of medical science and the health of the American people."

The American Medical Association, to which you belong, and your State Society must meet their responsibilities through the following means:

1. ***"By encouraging the further development of medical knowledge, skills, techniques and drugs; and by maintaining the highest standards of practice and health care."***

It is up to you, doctors, in your local communities and in your local hospitals to continuously maintain high standards of health care; to forcibly eliminate that which is obsolete and to foster that which is good.

2. ***"By creating incentives to attract increasing numbers of capable people into medicine and other health-care professions."***

Your AMA, through voluntary contributions to ERF, and your State Society, through CES and through the many programs your Society fosters in conjunction with public and voluntary agencies, are continually moving forward to follow this precept. But the word of the individual doctor to the individual student will mean more than all of the money we can contribute or all the seminars we can conduct. Foster your profession and the entrance of students into the paramedical fields in the social groups you know and in the students of the families you serve.

3. ***"By advancing and expanding the education of physicians and other groups in the health-care field."***

Here again, your AMA, through its national meetings, and your State Society through its annual meeting and symposiums given in conjunction with the University of Wisconsin Medical School and Marquette School of Medicine, are continually trying to expand the education of physicians. Much hard work is done in this field by various committees and commissions of SMS.

4. ***"By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners."***

Thus far, five new medical schools are in operation, and five more are in various stages of planning and construction. Our State is faced with the problem of a private school—Marquette School of Medicine. It is the duty of all of us to encourage in whatever way we can the continuation of Marquette as an outstanding school of medicine and foster by all means at our disposal, methods to increase the numbers of students at both of our excellent schools of medicine.

5. *"By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care."*

We in Wisconsin can be proud of the outstanding performance of our profession in the field of voluntarism. Many doctors of our State have served voluntarily in Vietnam. Nurses and physicians have served on the good ship HOPE. Yes, the medical profession in Wisconsin stands ready to help.

6. *"By developing techniques in practices that will moderate the cost of good medical and health care."*

To meet this purpose we will be required to industriously use new methods. Doctors in many areas of our State are involved in the regional medical care programs and in others are ready to serve in state comprehensive planning. These are the programs which will help produce quality medical care at a cost everyone can afford.

7. *"By seeking out and fostering means of making all health-care facilities—physicians' offices, hospitals, laboratories, clinics and others—as efficient and economical as good medical practice and attention to human values will permit."*

As your President, I have been invited to committee meetings and to meetings of physicians, hospital administrators, clinic managers, and others, and I can truthfully say that all of the people whose primary concern is better medical care have this paragraph in mind. It is my belief that our State is outstanding in the development of "efficient and economical medical practice."

8. *"By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient."*

Your State Society in all of its commissions and committees is vitally concerned with preserving this concept. At no time have I ever found any division of thought that the personal physician is not paramount in the care of his patient.

9. *"By maintaining the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice."*

Remember, doctors, that it was your Society under the direction of the Commission on Medical Care Plans and the Council that the words "usual, customary and reasonable" became part of the prepaid health insurance concept and then found its way into the medicare program. I am sure neither the AMA nor SMS will in any way at all reduce its vigilance in preserving the practice of medicine.

10. *"By maintaining the highest level of ethics and professional standards among all members of the medical profession."*

This responsibility has been and is carefully and thoroughly being carried out by our state grievance committee, county grievance committees, and by our various hospital committees. In continuing our high ethical and professional standards we must maintain and will maintain an important part of the structure of organized medicine.

11. *"By continuing to provide leadership and guidance to the medical profession of the world in meeting the health needs of changing populations."*

This last statement of the House of Delegates of the AMA may seem remote to those of us in a midwestern state. But let me assure you that many members of our State Medical Society have been active in the World Medical Association, and I am sure there are many more who will willingly serve on committees and will personally help solve problems that confront others in these changing times.

Yes, doctors, it is a new year and the problems of 1967 have followed us. However, with the help of organized medicine and the help of physicians throughout our State in maintaining the 11 principles enumerated above, Wisconsin will continue to be a healthy state.

H J Kiel MD

AMERICAN MEDICAL ASSOCIATION PURPOSES AND RESPONSIBILITIES

A copy of these 11 principles, suitable for framing and display, was sent to all members of the AMA with a request that it be posted where patients and other friends can read it. The AMA further urges that physicians cite this statement as fundamental whenever health-care matters are being considered and activate programs that will help to achieve these purposes.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

JANUARY 1968

Vol. 67 No. 1

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

EDITOR'S NOTE: The plentiful problems of Town and Gown will be aired at the second symposium on this subject scheduled for March 23, 1968, at the State Medical Society building in Madison. A. Y. Gerol, M.D., a practicing neurosurgeon, limns one of them in a forceful, thought-provoking guest editorial. That the situation he writes about is not confined to the Milwaukee area is emphasized by a bulletin from the Association of American Medical Colleges that discloses that, as of October 1967, 22 four-year schools out of 72 reporting had in operation a school-wide faculty group practice plan. Sixteen additional schools stated they were definitely planning to organize such a group. Although there were ten different arrangements for distribution of net professional earnings, most income ended up as "salary support." Of particular interest is that while these plans increased fourfold in the years 1945 to 1965, five new group practice plans became operational in the year 1967.—D. N. G.

GUEST EDITORIAL

The Peripatetic Practitioner

■ A PROBLEM FACING Wisconsin Medicine, as well as American Medicine as a whole, arises not so much in what the federal government does to the medical profession but how the profession has divided itself. In one way it begins with the research grant that subsidizes a physician in a university; the university medical center is then able to attract a special sort of doctor. This physician, however, usually feels that the economic inducements should be even greater and so a "private practice privilege" is granted by the university.

At this point the "academic" physician competes with the private practitioner. The concept of the medical school complex benignly practicing in symbiosis with private medicine becomes impossible. The two become competitors, in an economic sense, rather than colleagues.

Marquette Medical School does not have its own hospital complex; its teaching material is gleaned from the Milwaukee County Hospital, the Veterans Administration Hospital, and some nearby private institutions. In this structure the university practitioner supposedly practices "full-time," but is permitted to supplement his income through private practice privileges in nearby hospitals. It is hoped that this system will elevate the standard of medicine by attracting more highly qualified personnel but it can only accomplish the opposite. What it does attract is an individual who measures the time he allots the university and students—he considers this "full-time" and then wanders off to his private practice.

The private practitioner must maintain offices and hire personnel to staff them. He cannot hope to compete with a university treasury, governmental subsidies, or private endowments. The university practitioner does not have to pay for office space or ancillary personnel.

The university physician who practices at a distance from the home complex conjures up the spector of the peripatetic practitioner. How such a physician is able to offer close patient care in one place and offer teaching ability at the same time in another hospital escapes understanding, yet this is the drift at Marquette Medical School. And what of the student? Gone, it seems, are those days when the university professor experimented in the laboratory or studied in the library or sat in his office and meditated after his formal teaching hours of the day. What we have now is the university physician who speeds through his work in some fashion between the hours of 7 A.M. and 1 P.M. so that he can get over to his private practice. Indeed, at Marquette some practitioners do not make daily formal rounds, but leave it to residents to care for the public patients. Medical students, interns, and residents are losing the precious moments spent learning from the attending physician at the patients' bedside. These moments once lost are lost forever as a teaching device, and yet as this is written there are days when residents on certain of the specialty services are not afforded formal rounds with the attending physician.

In the distance we hear of the computerized diagnostic unit, but there is an art in medicine that no machine can ever mimic. This art is lost when the student is poorly taught by a part-time practitioner in a university and a part-time practitioner in private medicine. The only way to prevent this from happening is to sharply curtail the university's inclination to subsidize personnel in the private practice of medicine. The use of public buildings and funds for private gain must be restricted. The university physician must once again assume the mantle of a respected colleague and not become a medical buccaneer, with letters of marque from a hospital political administration. — A. YALE GEROL, M.D., Racine

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The Spectrum of Patient Care Viewed by a Nurse

By ELEANOR C. LAMBERTSEN, Ed.D., R.N., New York, New York

Continued from December 1967 issue at page 582.

Nursing ministrations are primarily related to the maintenance or restoration of normal body functions or life processes. It is further hypothesized that it is the potential adaptive response of the individual to illness or disability which influences the nursing function. The ultimate goal of the program of nursing care is to mainain or achieve that degree of health attainable for and by the patient.

Problems associated with the shortage of talented manpower in nursing have resulted in increasing attempts for more effective utilization of available nurses. However, all too frequently, the action that is taken has not been based upon evidence of the needs of patients or upon the effect of change in routines upon the quality of patient care. The emphasis has been on what is not nursing, rather than upon what is nursing. An example of analysis of services on the basis of the therapeutic needs of patients will serve to illustrate the concept of a spectrum of care from the home to the hospital for patients of a particular age group.

The Methodist Hospital of Brooklyn has been actively engaged in an appraisal of the forces and factors within the hospital that affect the quality and scope of nursing practice and the quality of nursing care. One recommendation for change in hospital routines was that the dietary department should serve and distribute meals to patients instead of the nurses on each ward unit.

The decision that this service would be provided by the dietary department was not innovative, for this practice is increasingly prevalent in hospitals.

Presented during the Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison, Oct. 16–20, 1967.

Doctor Lambertsen is Director, Division of Nursing Education, Columbia University Teachers College.

What was unusual was the decision that nursing service would retain the total responsibility for meal services on the Pediatric Ward. Feeding all patients requiring assistance is the responsibility of nursing service personnel, but in the Pediatric Ward, nursing service personnel will also serve and distribute meals to the children.

Understanding of the basic concepts and principles of physical, psychological, and social maturation is basic in understanding the meaning and response of a patient to hospitalization. Numerous reports of research involving children reveal the effect of hospitalization upon children and the effects of unrelated associations with numbers of unfamiliar caretakers during a period of stress. Separation from the normal life situation is likely to produce tension, anxiety, and fear for anyone admitted to the hospital, but it is intensified for the child. Unfamiliar situations and strange people are primarily threatening and may arouse fright. How can the nurse reduce the elements of strangeness and reduce the number of caretakers?

An appreciation of these basic concepts influenced the decision of the nursing service staff of the Methodist Hospital of Brooklyn. Meals are a familiar experience for the child and the rituals associated with eating may be highly individualized at home. If an objective of nursing is to reduce the elements of strangeness and to approximate, insofar as possible, the familiar setting for the child, the head nurse will attempt to stabilize the assignment of nursing service personnel and to provide the means by which the staff will become familiar with the habits and customary life routines of the child.

What can the nurse learn from the mother that will facilitate the nurse becoming a familiar person? What are the rituals that are important to the child during meal hours? The rituals may be relatively simple: some children drink milk out of a cup rather than a glass; others like their food (meat, potatoes and vegetables) all mixed up; some eat dry cereal with their fingers and drink their milk; some are used to having their food placed in certain positions on their plate; some prefer to eat all their potatoes first, then the vegetables and then the meat or fish. There are numerous other examples of individual habits acceptable at home—habits that, if reinforced in the hospital, encourage the child to eat and reduce the element of strangeness.

Eating, bathing, sleeping, and toileting represent routines for the child—routines which may be comforting if reinforced, but stressful if they differ to a large degree in the hospital. Every attempt should be made to reinforce relationships and reinforce life experiences. Of course, the ideal situation is to permit and encourage the mother, if it is possible, to participate in the caring activities of the child during hospitalization.

In the example cited, the nursing service staff of the Methodist Hospital of Brooklyn analyzed the activity of food service and the meaning of this service in the therapeutic plan of care for children. The decision that meal service for children was a nursing service responsibility was based upon the results of research and studies that demonstrated the effect of fragmented personal relationships as compared to sustained relationships in caring for children in hospitals, and the effect of familiar life experiences in the reduction of stress of the hospitalized child.

Another example of the analysis of an individual's needs for nursing care can be demonstrated through a statement of objectives for nursing care. In this instance, the group of patients refers to the chronically ill and aged and the objectives apply to nursing care in any health care institution:

1. To assist the patient to achieve his fullest potential for self-care.
2. To evaluate the potential of the patient and to assist the patient to retain and/or restore functional ability.
3. To assist the patient to meet needs for independence as well as to sustain his dependency needs.
4. To adjust institutional routines and procedures to the slower performance rate of the patient.
5. To adjust institutional routines and procedures which relate to the basic physiological and psycho–social needs of the patient to his normal life pattern or habits.
6. To recognize the significance of the patient's concern with bodily functions and symptoms.
7. To provide opportunities for the patient to question and reinterpret all explanations or instructions.
8. To preserve the dignity and integrity of the patient in all nurse–patient relationships.
9. To anticipate that any change is potentially threatening or stressful to the patient.

These objectives are also derived from research in the sciences underlying the practice of nursing and serve as guides for individualizing plans of nursing care.

It is my premise that present attempts by physicians and nurses to define practice in terms of the knowledge, judgment, and skills required for safe, efficient, and therapeutic services to individuals and families is the most significant trend today—one that will result in many changing patterns of practice and many changing relationships in and among the health occupations. The spectrum of patient care requires an effective, efficient, and coordinated health team capable of providing services in a wide range of health institutions, a health team that provides comprehensive personal health services of a high quality for all people, services which enhance those directed toward:

. . . promotion of positive good health;
. . . application of established preventive measures;
. . . early detection of disease;
. . . prompt and effective treatment;
. . . physical, social and vocational rehabilitation.

SPECIAL TO THE JOURNAL

Services Offered by *TB OUTPATIENT CLINICS* in Wisconsin

■ SERVICE IS THE PURPOSE

Providing service for the patient is the guiding purpose of the state's TB outpatient clinics.

Originated as early as 1919, the clinics' early activity involved providing followup care for sanatorium dischargees.

A later service was assisting in TB diagnosis of referrals from private physicians and nurses. At present, clinic personnel help determine the risk of TB breakdown for reactors to the tuberculin skin test and prescribe preventive drug therapy as required.

■ WHAT ARE OUTPATIENT CLINICS?

They are clinics for the diagnosis and treatment of persons having TB or suspected of having TB. Clinics may be operated by counties or by the Wisconsin Division of Health. They may charge fees for services but the law gives them financial aid on a per patient basis.

■ WHAT STATE AID IS AVAILABLE?

The State of Wisconsin will provide aid to the clinic for each patient visit. However, it will deduct from this amount any fees collected from the patient or another source.

■ WHICH CASES ARE ELIGIBLE FOR STATE AID?

Any person suffering from or suspected of having TB, described by the statutes as follows:

1. Has symptoms suggesting TB.
2. Has had a medical examination suggesting TB.
3. Has x-ray evidence suggesting TB.
4. Has converted to a positive skin test within the past three years.
5. Is a close school contact to a suspected TB case and has a positive skin test.
6. Is a close employment contact to a suspected case and has a positive skin test.
7. Is a household contact of a suspected case (positive skin test is not required).

The State Medical Society's Division on Chest Diseases is cooperating with the Wisconsin Anti-Tuberculosis Association and the Wisconsin Division of Health in disseminating current information on the chemoprophylaxis program in Wisconsin. The State Medical Society, through its Speakers Service, will provide a speaker at county medical society meetings on the subject of chemoprophylaxis for the positive reactors to the tuberculin test.

The above article is reprinted with permission of the Wisconsin Anti-Tuberculosis Association. This material is contained in a pamphlet which is available to patients who are positive reactors to tuberculin testing. Physicians may order a supply of these pamphlets from WATA, P.O. Box 424, Milwaukee, Wis. 53201.

■ ADDITIONAL FACTS

When clinic services are completed in less than 12 hours, no determination of legal settlement is required. If the services or treatment take longer than 12 hours, the patient may be referred to a sanatorium for inpatient treatment under Wisconsin's Free Care Law for TB.

Not more than one visit for any one patient can be credited within a period of less than 12 hours. Neither can a visit be credited if it is merely to pick up drugs and does not require medical services. The state also does not allow credit for more than one visit where a single fee has been established by the clinic for a particular service.

■ WHAT ABOUT TB DRUGS?

Drugs necessary for prevention or treatment may be made available to the patient free or at a cost determined by the clinic.

■ READY TO ASSIST

The outpatient clinics stand ready to assist any physician or nurse who wishes to make use of their specialized diagnostic and preventive services.

TB clinic services are also provided by local health departments in Milwaukee and several other counties.

LOCATION OF TB OUTPATIENT CLINICS

1. Pureair Sanatorium, Bayfield 54814
2. Mount Washington Sanatorium
   Cleveland St., Eau Claire 54701
3. Middle River Sanatorium, Hawthorne 54842
4. Pinehurst Sanatorium, Janesville 53545
5. Riverview Sanatorium
   Route 1, Kaukauna 54130
6. Willowbrook Sanatorium
   3418 Washington Road, Kenosha 53140
7. Morningside Sanatorium
   300 Femrite Drive, Madison 53716
8. Oak Forest Sanatorium, Onalaska 54650
9. Rocky Knoll Sanatorium
   Route 1, Box C, Plymouth 53073

   Sheboygan Health Department
   (branch outpatient clinic)
   1208 South 8th Street, Sheboygan 53081
10. Racine County Clinic
    2433 South Greenbay Road, Racine 53406
11. River Pines Sanatorium
    1800 Sherman Ave., Stevens Point 54481
12. Mount View Sanatorium
    Route 4, Wausau 54401
13. Muirdale Sanatorium, 10437 Watertown
    Plank Road, Wauwatosa 53226
14. Hickory Grove Sanatorium
    Route 1, West De Pere 54178
15. Maple Crest Sanatorium, Whitelaw 54247
16. Sunny View Sanatorium, Winnebago 54985

Minutes of Council Meeting

MADISON, NOVEMBER 4, 1967

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:00 p.m. on Saturday, November 4, 1967, at the State Medical Society.

All voting members were present except Doctors Boren and Chojnacki.

Officers and others present were President-elect James; AMA delegates Bernhart and Galasinski; alternate delegates Collentine and Picard; Messrs. Crownhart, Koenig, Reynolds, Brower, Maroney, LaBissoniere, Salt, T. H. Murphy, R. B. Murphy, Kluwin, Tiffany, Gill, White, and Brown of AMA field service; Mrs. Anderson, Misses Cordts and Pyre.

Present for special orders: Doctors Hirschboeck and Jorris, and Mr. Robert Neal Smith; Mr. James, agent, and Mr. Christian of Time Insurance Company.

2. Approval of Minutes

On motion of Doctors Grand–Ludwig, carried, minutes of the July 30, 1967, meeting were approved.

3. Special Order—Federal and State Health Planning Programs

In order to provide members of the Council with current information on these several health programs involving public funds, the Executive Committee had arranged this special presentation. There were comprehensive reports by the following, each of whom answered questions of Council members:

a. J. S. Hirschboeck, M.D., on the Wisconsin Regional Medical Program, Inc.
b. E. H. Jorris, M.D., on the Comprehensive Health Planning and Public Health Services Act
c. Mr. Robert Neal Smith on health-related programs of the Office of Economic Opportunity.

In reference to the state-oriented study by the Governor's Task Force on Medical Education, Doctor Kief read a recent letter to its chairman, authorized by the Executive Committee, which stated the Society's position in substance that "the planning of a third medical school should follow the augmentation of the facilities of the University of Wisconsin Medical School, and a most careful evaluation of the possibilities of Marquette becoming an integral part of a state system of medical education."

4. Oath of Office

The oath of office was administered by the chairman to M. F. Huth, M.D., new member of the Council succeeding Doctor Davis, deceased.

5. Report of Committee on Economic Medicine

The committee reported recommendations on two programs for Society members:

a. Group (Franchise) Term Life Insurance Program

The committee recommended that a term life insurance program as submitted by Charles V. James, agent for Time Insurance Company, be offered to members as a supplement to the existing Bankers Life program. In substance, the proposal offers fully paid members in active practice term life insurance protection at a fixed annual premium with the face amount of the benefit decreasing as the age of the insured member increases.

Following discussion, the recommendation was approved on motion of Doctors Van Hecke–Ludwig, carried.

b. Group Pension Plan

A proposal by Prudential Insurance Company pursuant to the Self-Employed Individuals Tax Retirement Act had been reported to the Council in July, at which time it requested the committee to give the proposal further study in comparison with other programs currently available, including that offered by the AMA.

The results of this study were reported, together with the committee's recommendation that the Prudential program, which embodies both fixed dollar and variable annuity options, be offered to Society members.

On motion of Doctors Kief–Nordby, carried, the recommendation was approved.

6. Report of Executive Committee

a. Proposed Bylaw Amendment

There is an element of conflict in the bylaws on the question of whether membership in a county medical society should be determined by county of residence or location of practice. The original bylaw provision bases eligibility on county of residence, and a later provision states that a member removing his "principal practice" shall not be eligible to continue his membership in that county.

The Executive Committee felt that while physicians most often practiced in their county of residence in days past, suburban living is now common and membership should be in the county where they have their principal practice, meaning the major percentage of their time.

It recommended that a bylaw amendment to the effect that the place of principal practice of a physician determines his membership in a county medical society be submitted to the House of Delegates.

On motion of Doctors Egan–Houghton, carried, the recommendation was approved.

b. Society Bowling Tournament

The committee has asked that staff work with the Planning Committee and the Auxiliary in determining interest and proceeding with plans for a Society bowling tournament.

c. Scientific Sections—Invitation to Meet with Council

The committee considered the suggestion that as a means of providing essential information on Society activities to representatives of the sections that vote in the House of Delegates, they be invited to a Council meeting when the agenda will allow an opportunity for their participation, such as at the time material is presented for forwarding to the House. It concluded that such an invitation be extended at an appropriate time, but without creating a special occasion.

d. Congress on Socio-Economics of Health Care, Chicago, March 22–23, 1968

The Executive Committee approved attendance by the president and president-elect, and by Doctor Schulz as chairman of the Committee on Economic Medicine.

e. Conference on Utilization Review, November 25, 1967

This national conference immediately precedes the AMA convention in Houston and will be attended by President-elect James. The committee also recommended that Doctor Mason, chairman of the advisory committee of the Commission on Medical Care Plans, be requested to attend if possible.

f. Pastoral Counseling Center, Inc.

The committee was advised of this recently incorporated organization which "shall operate exclusively for religious, charitable and/or educational purposes including, without limitation, the following purposes, which are based upon a recognition of the integrity of the individual person and of the family and also the value of one's own professed religious faith and practice: to make available to Milwaukee and Wisconsin communities religiously oriented, pastoral counseling to all who are in need of such services; to provide an accredited training setting for clergymen in a clinical pastoral counseling program; to provide the professional and lay community with expert pastoral counseling, consultation, and education."

The Executive Committee approved Doctor Kief's appointment of A. J. Baumann, M.D., of Milwaukee, as the initial member on the board of directors, which is to include "one psychiatrist nominated by the State Medical Society of Wisconsin," and recommended that the Society continue representation in the future by presidential appointment.

On motion of Doctors Egan–Nordby, carried, the above report of the Executive Committee was accepted.

7. Report of Finance Committee

In executive session, with the Secretary present, the Council took the following action:

APPROVED, on recommendation of the Finance Committee, the appointment of Earl R. Thayer, in the classification of an associate secretary, at a salary of $27,500.

APPROVED the recommendation of the Finance Committee that the salary of the Insurance Director, holding the classification of associate secretary, be increased from $27,500 to $31,000 effective January 1, 1967.

APPROVED the recommendation of the Finance Committee and the Executive Committee, upon suggestion of the Secretary, that there be authorized a committee advisory to the Finance Committee to review and offer recommendations on salaries of executive personnel.

Composition of the advisory committee is:

- Chairman and Vice-chairman of the Council
- Chairman of the Council's Finance Committee
- Chairman of the Commission on State Departments
- Chairman and Vice-chairman of the Commission on Medical Care Plans
- Chairman of the Reference Committee on Finances of the House of Delegates
- The President and President-elect as ex officio members.

APPROVED a study of the current pension plan established for employees, to be conducted by the Finance Committee and consultants.

REAFFIRMED, on recommendation of the Finance Committee, that fiscal notes be attached to any requests for new projects, and that such include staff time involved.

AGREED that beginning January 1, 1968, the hospital daily room rate in the WPS–Blue Shield insurance program for employees be $35, and that all costs of the Blue Shield coverage be carried by the Society, with charge-backs to appropriate accounts.

8. Further Report of Executive Committee

The Council, on motions made and seconded, accepted the following recommendations of the Executive Committee:

That the present annual meeting schedule be retained, and study be made of the future possibility of moving business and scientific sessions into the Arena.

Elected L. C. Pomainville, M.D., of Wisconsin Rapids, as Society Historian.

Terminated the inactive Committee on Clinical Medicine.

Appointed William E. Funcke, M.D., of Beaver Dam, as advisor to the Wisconsin State Medical Assistants Society.

Received a report that existing policy provides for reimbursement for such meetings as an AMA convention to the president, president-elect, chairman of the Council, the delegates and alternates, and, in some cases, representatives of various committees. Budget planning is difficult, however, when past officers, Council members, and others attend these meetings without notice and expect reimbursement, or when members at large ask to attend various national conferences of special interest. The committee recommended that a written request for approval to attend such meetings as official Society representatives be on file two months before the meeting.

9. Health Service Data Corporation

The Council accepted, on motion of Doctors Nordby–Houghton, the report of Doctor Sisk on activities of the Health Service Data Corporation. It expressed appreciation to Doctor Sisk, asked that he continue to serve on the corporation, and that he submit further reports from time to time.

10. Resolutions

The Council approved for submission to the House of Delegates of the American Medical Association, meeting in Houston in late November, three resolutions to the following effect:

In statistical reports on health care costs, the AMA itself, and as an official position with government agencies, identify the components of these costs.

In submission of resolutions to the House, annotations be provided to indicate previous actions, if any, pertaining to the same or related subjects.

Resolutions involving expenditure of funds be accompanied by a fiscal note.

11. Adjournment

The meeting adjourned at 5:30 p.m.

Respectfully submitted,

C. H. CROWNHART
Secretary

Approved:

JAMES C. FOX, M.D.
Chairman

(Subject to formal approval by the Council.)

WISCONSIN'S HEALTH by E. H. JORRIS, M.D., State Health Officer

NURSING HOMES COMPLETE FIRST YEAR UNDER MEDICARE

On January 1, 1968, nursing homes participating in Medicare completed their first year cf experience. The Division of Health surveyed 371 skilled care nursing homes in Wisconsin and recommended certification to the Social Security Administration of 179 totaling 12,511 beds. Certification is dependent on the facility meeting conditions which will assure patients of receiving high quality post-hospital care.

Many nursing homes have not been able to qualify for participation in the program because they are primarily engaged in providing custodial and personal care and such care is not covered by the program.

This new part of the Medicare program provides payment for nursing home care of up to 100 days for each spell of illness, if a physician certifies as to the medical necessity. The law further provides that the beneficiary must have been a patient in a participating hospital for three days prior to admission, then must be admitted to the extended care facility within 14 days after hospital discharge.

In addition to surveying nursing homes and making recommendations for their certification, the Division of Health offers consultations to help skilled nursing homes meet the conditions of participation and to qualify as providers of extended care services.

Hospital and home health agency participation in the Medicare program began on July 1, 1966. Today 168 of the 172 general hospitals in Wisconsin are participating in the Medicare program. Psychiatric hospitals and tuberculosis hospitals which are equipped to provide diagnosis and treatment are also participating in the program. A Medicare beneficiary must be an inpatient of a certified hospital in order to be eligible for program benefits and a hospital must be certified before it can claim reimbursement for care of beneficiaries under the program.

Wisconsin citizens who are eligible for Medicare social security benefits have access to certified extended care facilities and hospitals in all areas of the state. Although there continue to be professional staffing problems, the health care facilities and physicians in Wisconsin have effectively met the challenge of the federal Medicare legislation.

NURSING HOMES DIRECTORY LISTS 34,267 BEDS

There are 34,267 beds available for patients in nursing homes and homes for the aged in Wisconsin which are listed in the 16th annual directory of the Section of Hospital and Related Services of the Division of Health.

Proprietary and other nongovernmental nursing homes are regulated and licensed by the Division of Health of the Department of Health and Social Services.

Three types of licenses are issued: 354 for skilled nursing care homes; 47 for homes for limited nursing care; and 100 for homes for personal care.

There are 22,690 beds provided by nongovernmental owned homes in the "skilled care" category. In addition, there are 40 county homes with 7,289 beds which qualify for the "skilled care" designation. The home for state veterans at King provides another 573 beds in this category. Overall, there are 30,572 beds available in homes that provide skilled nursing care. Of these beds 12,445 are in homes certified as extended care facilities for Medicare beneficiaries. The remaining beds are in the 147 "limited care" and "personal care" homes.

Since 1953, when there were only 12,000 beds, the state has witnessed a near-threefold expansion in the numbers of beds available for its aged population needing nursing home care.

The directory lists those homes which are of fire-resistive construction and those which are protected by automatic sprinkler systems. Approximately 22,000 beds are in fire-resistive structures and 6,000 beds are fully protected by automatic sprinkler systems. There are 187 small nursing homes, with a total of 5,000 beds, which are nonfire resistive. These homes are not permitted to have bed patients above the first floor and all are required to be fully protected against fire by automatic sprinkler systems not later than July 1, 1969.

Since 1964, because of higher care standards and the public's demand for safe accommodations and proper nursing care, more than 100 nursing homes with more than 2,000 beds have closed. These were in old frame homes, not designed for nursing home use. However, an average of 2,000 beds per year has been added in newly constructed, modern fire-resistive or sprinklered nursing homes since 1964.

Copies of the new directory, which was mailed late in December, have been sent to every newspaper in the state, to every public health nursing department, to all hospitals, and to others. Persons who are unable to consult a directory in their own community may receive a copy on request to the Section of Hospital and Related Services of the Division of Health, Box 309, Madison, Wis. 53701.

the wisconsin medical journal

VOLUME 67/NUMBER 2 FEBRUARY 1968

SYMPOSIUM
The Geriatric Patient
PROFILE OF THE AGED

PRESENTED APRIL 5, 1967, EAU CLAIRE, WISCONSIN

This Symposium was made possible by grants from and with the cooperation of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin; the Wisconsin Psychiatric Institute; Division of Mental Hygieue, State Department of Public Welfare; Wisconsiu Academy of General Practice; Sandoz Pharmaceuticals; The Merck Sharp & Dohme Postgraduate Program; Marion Laboratories, Inc.; McNeil Laboratories, Inc.; CIBA Pharmaceutical Company; Schering Corporation; Roche Laboratories; Eli Lilly and Company; Smith Kline & French Laboratories; and the Northwest Psychiatric Clinic.

GERIATRICS is a rather new development. It has come about as a result of fascinating advances in the medical sciences. It is interesting to note that a study in Europe in the year 1775 indicated that half the population was dead by the age of 10 years. Fifty years later only a third of the population had succumbed at this age. These changes were thought initially to be a result of the introduction of the Jenner smallpox vaccine at the turn of the century, but it was shown actually to be an improvement in general public health measures. By 1900 the average life expectancy had risen to 47 years while today it has jumped precipitously to 71 years. More progress has been made in the field of medicine in the last 25 years than in the preceding 2500. It has been estimated today that about one fourth of the total population who has ever reached the age of 65 in the history of time is alive today. Roughly those over 65 have been increasing about twice as fast as the rest of the population since 1900.

Control of infectious diseases accounts for most of this remarkable change in mortality in the last half century. For example, in 1911 tuberculosis was the leading cause of death in the Metropolitan Life Insurance Company industrial policy holders with a rate of 255 per 100,000. By 1960 this rate was 5 per 100,000. The four principal diseases of childhood, measles, scarlet fever, whooping cough, and diphtheria, are no longer the menace of previous years, and more recently polio has dropped precipitously in the mortality figures. Childbearing is safer now and heart disease has become the number one killer.

—JESSE J. BARRON, M.D.

The Geriatric Patient and the Physician

By JESSE J. BARRON, M.D., Minneapolis, Minnesota

■ AGING MAY BE DEFINED simply as the changes which occur in tissues and performance with the passing of time. It begins with conception and ends with death. Geriatrics, on the other hand, deals with the problems or the negative aspects of aging.

The simple facts about aging have been known and described for centuries, but both the patient and those around him still refuse to recognize them. Instead, the older individual is considered to be ill rather than undergoing natural physiological changes. A person who is frail, dozing during the day, forgetful, repetitive and boring, selfish and perhaps concerned about death is not ill. All this is as normal as the comparable behavior of early childhood. We speak of a child going through a difficult stage, and we try to understand, sympathize, and help him through these trying times. The child is not considered ill. But where does physiology end and pathology begin? This now becomes the specialty of medical practice known as Geriatrics: the problem of differentiating between an ill person and an aging one in order to avoid serious problems in management. The physician must be able to recognize whether a patient is healthy although elderly; whether he is healthy and elderly, but significantly neglected; whether he is elderly and emotionally disturbed, or whether he is elderly and mentally or physically ill. It is tempting to allow healthy aging to become irreversible pathological aging. The healthy patient may become an invalid, and the independent citizen a public charge.

Aging brings about specific changes, anatomical as well as physiological. Alterations of the intracellular enzymes and fluids take place. There are changes in new protein formation and accumulation of metabolites within the cellular structures of the body. As a result, there is a loss of functioning in a variety of tissues in the body, while the function of other cells become exhausted and work less efficiently. There is a slow down in the cell or organ reaction.

Since survival of the cell is dependent on its blood supply, reduction of the circulating blood can bring about many changes. The natural aging process includes loss of elastic tissue and the deposition of calcium and fatty substances which narrow the vessel and subsequently reduce the flow of blood to the body.

Skin changes are manifested first by a loss of hair along the lateral aspect of the legs. The skin generally loses its tone and elasticity. The hair turns gray, the nails become brittle, the gums recede, the teeth become loose and fall out. Dry, itchy skin is very common, and skin cancer becomes more prevalent in this age group.

Increase in longevity is an underlying factor in the continuing increase in visual impairment. Presbyopia and cataracts are a natural consequence of aging. Over one million Americans in the 40-or-over age group have glaucoma and aren't aware of it, and another million are functionally blind and cannot read. Glaucoma is present in about 2% of the adult population. When impaired vision interferes with a patient's ability to read medication directions, diet instructions, insulin dosage or special procedures, then supervision becomes necessary and a forced dependent relationship cuts deeply into the alert individual's ego. The greatest hope for reducing the number of the geriatric blind lies in early diagnosis and treatment.

It is estimated that almost everyone over the age of 65 has some measureable hearing impairment, although he is often not aware of it. Up to 11% of this age group need medical attention for their hearing. Deafness often has the tragic association of paranoid behavior patterns, a feeling of being "left out," a withdrawal from family and friends. Hearing aids, surgical corrective procedures, and courses in lip reading may be very helpful. Determining the patient's specific needs can be significantly important in breaking the communications barrier.

Presented at a Symposium of "The Geriatric Patient" under auspices of the Division on Nervous and Mental Diseases of the State Medical Society of Wisconsin and others, Eau Claire, Wis., April 5, 1967.

Doctor Barron is Associate Editor of *Geriatrics*, Practice of Internal Medicine.

Changes of the lungs in the aging process are brought about by the accumulation of repeated infections, exposure to irritants, and at times from heart weakness. Symptoms resulting from lungs that are scarred, congested, or have lost elasticity would be shortness of breath, weakness, and cough.

Gastrointestinal symptoms commonly occur in geriatric patients because of changes in the flow of gastric juices and enzymes. The bowel often loses its tone from the improper use of laxatives.

In the musculoskeletal system aging causes general muscle weakness, a tendency to hernias, and a more prominent abdomen because of the sagging musculature. Local and generalized osteoarthritis and osteoporosis to some degree are almost synonymous with aging.

A surplus of brain cells at birth are diminished through the years by the accumulative effects of infection, trauma, and the arteriosclerotic process. Since these cells never regenerate, a point is reached when the brain loses its efficiency. These symptoms are commonly manifested by impaired memory, coordination, weakness, and confusion. In the cerebral arteriosclerotic patient the pathology is in the blood vessel and the cell changes may be reversible to some degree. Anemia due to any cause, but commonly associated with a poor nutritional state in the geriatric patient, reduces the oxygen-carrying capacity to the brain, aggravating the arteriosclerotic ischemia. Correcting the anemia may help significantly to clear the cloudy sensorium.

In the presence of systemic infection, a toxic state may develop in a brain already on the brink of senility, pushing the patient into confusion and lethargy resembling a major stroke. Excessive sedation could have a similar effect. When the infection has cleared or the sedation is removed, the patient's previous state of alertness returns.

With coronary arteriosclerosis, as with arteriosclerosis of other organs, cells die and are replaced by scar tissue. When a sufficient amount of scar tissue exists the heart becomes inefficient and weak. Heart weakness, or congestive heart failure, may occur also in hypertensive or rheumatic valvular heart disease. A reduced cardiac output associated with cerebral arteriosclerosis has an effect similar to anemia in reducing the oxygen-carrying capacity of the blood to the brain. By strengthening the heart contractions and correcting the arrhythmia with digitalis preparations the brain may function more effectively and the patient is more alert and comfortable.

However, primary brain cell damage may occur, in the presence of clean cerebral vessels, producing fixed types of senile psychoses that don't respond well to medical or psychiatric management. At autopsy these brain cells show the characteristic argentophyllic staining. The clinical manifestations are the (1) paranoid type, (2) the presbyphrenic type with a fixed scheduled existence, (3) the simple deteriorative type with frequent incontinence of bowel and bladder, and (4) the depressed or agitated type. These patients fill the nursing homes and state hospitals.

The physician who treats the older age group soon recognizes the different manifestations of this group. Problems in communication include language barriers, where the patient's use of English is very limited both in expressing and understanding. He may have an aphasia from a stroke or be too confused to give an accurate history of his complaints. It is much too frequent to find a patient with a markedly distended overflow bladder or a large fecal impaction without his awareness of the problem. It is distressing also that many nurses attending the patients in the nursing homes are not aware of it either. They describe urinary incontinence as not unusual for this patient, or the frequent runny stools as being the natural consequence of the patient's injudicial use of laxatives, taken by the patient without the nurse's knowledge. Prostatism in the older male is so frequently encountered that it is almost taken for granted. Acute urinary retention may develop in the presence of asymptomatic prostatism not only from an inflammatory or infectious process but also from anticholinergic medications used to treat peptic ulcers, gastritis, and colitis. This same medication may precipitate acute glaucoma in an eye that is predisposed to it. A careful history might give adequate warning to the doctor that this drug is contraindicated, but as previously mentioned, that history may not be available. Thus the doctor must be on his guard. It is very amazing to hear relatively alert patients describe the wide variety of symptoms attributed to one condition, such as urinary retention. It is

equally remarkable to hear some nurses describe the same condition. The geriatric-oriented physician or nurse would be able to anticipate the problem more readily, but even more importantly, to try to prevent it. These problems of communication with the elderly patient again point out the close relationship to pediatrics in some age groups, the so-called veterinary practice of medicine. But in a more important aspect it is a distinct entity because of the pathophysiological changes peculiar only to Geriatrics.

In addition to symptoms which may or may not be expressed by the older patient, silent conditions may develop fairly commonly to confound the physician. Bronchopneumonia may resemble an acute abdomen or a cerebral vascular accident, and not too infrequently may be without symptoms or signs. Coronary occlusion, subdural hematoma, and pulmonary infarction can also be silent. Urinary tract infections can continue for months undiagnosed and without discomfort to the patient. Unfortunately this can develop into a pyelonephritis with permanent kidney damage adding further insult to kidneys previously damaged by the arteriosclerotic process. Not only can peptic ulcers develop spontaneously and be silent but also they can be precipitated or aggravated by a variety of medications including cortisone preparations for treating arthritis or asthma, anti-inflammatory drugs, and rauwolfia preparations. Extensive cerebral softening may exist without the usual neurological findings. In the presence of previous strokes classical reflex changes may not be evident to indicate the extent of a fresh involvement.

Precise diagnosis of the cause of death in the aged is usually a matter of great difficulty. Pulmonary pathology is especially difficult to assess, and yet it is perhaps the most commonly used cause of death in this age group. Bronchopneumonia and pulmonary edema come under this heading. In a recent study of octogenarians who came to autopsy, the correct cause of death was made in 50%, partially correct in 17% and totally incorrect in 33%. Missed diagnosis in sudden death included dissecting aneurysm, pulmonary infarction, rupture of the heart ventricles or aorta, and severe bleeding from peptic ulcers, intestinal diverticula or tumors. It is interesting to note that as the patient reaches later life the actual number of lethal conditions is reduced to a smaller group of pathological processes than those found in the 70- or 60-year-old subjects.

It now becomes more important than ever for the physician to recognize where physiology ends and pathology begins. Medical personnel must reject a rather classical orientation in our culture to the "sick old man." He must think, speak, and describe in accurate terms, to avoid labeling patients as senile when in actuality they are reacting normally within the restrictions of their age. Disabilities abound in the elderly, but disabilities are not necessarily active disease. Surgical and medical procedures which formerly were considered radical for the elderly, should be determined solely within the context of risk and benefit to the patient. He should not be denied the best possible care because he has reached an arbitrary chronological age.

I would like to see Geriatrics attain its full recognition as a medical specialty, with much greater emphasis given it in the training of both medical and paramedical personnel. However, I put it to those of you in the behavioral sciences: We physicians can more easily develop a realistic and compassionate approach to the medical problems of the aged if we can be convinced that there is a place of dignity for them in the world.

TAX GUIDE AVAILABLE

TAXES 1968, the annual tax dictionary and income tax guide published by the Wisconsin Taxpayers Alliance at Madison, is now available, the Alliance has announced.

TAXES includes information on all state and federal taxes collected in Wisconsin, and provides guidelines for filling out both state and federal income tax returns. Also included is up-to-the-minute information on recently approved increases in social security taxes to be paid by employees, employers and self-employed persons.

Copies of TAXES 1968 can be obtained for 50¢ from the Wisconsin Taxpayers Alliance, 335 West Wilson Street, Madison, Wisconsin 53703.

Physician-Patient Relationship in Geriatric Treatment

By JAMES L. ELMORE, M.D., Durham, North Carolina

■ THE CHARACTER of the interaction between the physician and his elderly patient, like that between the physician and his other patients, is influenced by several variables including: his medical specialty, the time he has available to spend with his patient, special interests of the physician, and the "fit" between the patient and the physician in the sense of mutual expectations of what is sought by the patient and what can be given by the physician. The personalities of the patient and physician as well as the severity of the illness also modify the relationship. Additionally cultural influences, perhaps unrecognized, affect the physician-patient relationship in geriatric treatment. A decline in resources and physical and intellectual capacities make the environment relatively more threatening for the aged patient. The persistence of sexual interest often results in bewilderment and guilt. The patient may be the victim of infantilizing attitudes on the part of the family and community.

The younger physician, like others in his culture, often harbors prejudice and dislike for association with the aged for a number of reasons. Experienced clinicians[1] have pointed out that the younger physician may feel guilty because of his attitude toward the older person. As a result he may feel some resentment of the elderly individual and react to this by a transparently insincere overprotectiveness. The older person feels the rejection of others and is often led to reject himself. If the physician is young, he may feel unnecessarily self-conscious and apologetic. If he has not come to terms with the fact of his own aging, the presence of the elderly patient may arouse his anxiety about growing old and result in a subtle rejection of the patient. If he is old he may feel superior, having weathered the years more successfully than his patient. If the younger individual has not resolved his feelings toward his own parents, he may react to the older person with an unrealistic idealization.

There is evidence that the physician, as well as others in the helping professions, often tends to react to his patients or clients with unconscious attitudes based on relationships with his own parents. If this has been fraught with difficulties, he may tend to project these onto his patients. Note the tendency of people to refer to their own personal experiences with aging relatives when discussing the vicissitudes of aging. Awareness of one's own bias in regard to the aged person is important in working harmoniously with him. Attitudes on the part of the doctor based on unconscious expectations do not help confused and insecure old persons who wish to identify with the younger person and to satisfy some of their dependency needs.

The older person is aware of his declining physical and intellectual powers, prestige, and often, financial resources: he unavoidably feels threatened by those who represent the younger generation just coming into power and reaching the peak of their productivity. One may find the older person reacting with some envy to physical vigor and youthful appearance of the physician or other personnel. For example, one may note a dignified and respected elderly gentleman remarking upon the attractiveness of the doctor's profile or his unlined features in an open and unabashed manner. Similarly an elderly lady may comment upon one's vigor and energy comparing this to her own diminished capacities. While this type of reaction to the younger person clearly is not neurotic, we can readily appreciate the envy in such remarks and the unfavorable comparison made by the older patient. If the physician himself harbors some hostility or feelings of superiority concerning his youth, social status, or greater physical and intellectual prowess, the interaction is likely to be stormy. In spite of a realistically dependent role on the part of the patient, the physician in the patient's fantasy may be a combination of parental and filial images. The pa-

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Presented at Symposium of "The Geriatric Patient" under auspices of the Division on Nervous and Mental Diseases of the State Medical Society of Wisconsin and others, Eau Claire, Wis., April 5, 1967.

Doctor Elmore is Instructor in Psychiatry, Fellow in Geropsychiatry, Administrator of Information and Counseling Service for Older Persons, Duke University.

tient's pride about his illusory parental authority is very sensitive and has to be taken seriously. The physician may have to play the role of a listening child when the patient tries to manipulate him like a parent. Recognizing that the patient expects and hopes for gratification of needs, the physician can afford to be more tolerant of this role.

The older person experiences change as a threat. Moving may symbolize death. Witness the aged person who states: "A rest home is the place you go to die." The senile individual may isolate himself from the outside world, miserable and unkempt, a starveling, although hoarding supplies and bric-a-brac. This can be viewed as a defense against deprivation and finally death. There is frequently a change in body image and in severe cases the person becomes more narcissitic. Fearful of loss, he jealously observes his physical capacities, dreading decline or disability. The individual becomes niggardly with the remainder of his brief lifetime and this is displaced onto his possessions. His increasing disengagement from the environment due to retirement, decline in social status, and loss of relatives and friends as well as fewer outside interests may encourage increased interest in the self. A survey of dreams of 52 aged persons[2] revealed that their dreams indicated preoccupation with loss of resources. The dreamer was pictured as weakened and ineffectual. He conceptualized himself as frustrated, vulnerable, and threatened by his loss of control over himself and his environment. His environment consequently became threatening, confusing, and fragmented. These dreams indicated a longing to repair or deny loss of resources. The dreams concerned with sex revealed anxiety and the sexual dreams of women depicted a gratification of dependent needs.

Hypochondrical attitudes and even bodily delusions may occur in the senium. This period of general decline in the function of organ systems obviously lends itself to the development of such trends. Over concern with bodily functions and anxiety may be expressed in terms of strange sensations and complaints of disorders in various organ systems. Thorough physical and laboratory examinations by the physician may play an important role in deterring further elaboration and fixation of such a trend into a way of life. After examinations the physician may point out to the patient that his tests did not reveal an underlying organic cause for the complaint. He then indicates that he recognizes the patient is troubled by these sensations or difficulties and points out that they may be due to the effects of emotion on bodily functions and an increasing awareness on the part of the patient of bodily sensations. The patient may be gently encouraged to return his attention to the underlying emotional disturbance, playing down the significance of the secondary symptom of bodily discomfort. This task of reorientation may succeed in helping the patient to give up such hypochondriacal preoccupations before they are so rigidly a part of the individual's personality. Of course the physician must not be ambivalent himself concerning the nature of the illness: if he resorts to further laboratory studies he immediately plants a seed of doubt in the patient's mind that the illness may after all be due to an organic problem. The whole procedure is very similar to the management of the younger hypochondriacal individual. Of course the development and maintenance of good rapport is essential if the patient is to accept the interpretation by the physician.

Sexual urges remain a strong influence upon the individual, and his attempts to maintain genital potency in the face of diminishing physical capacities may lead to ineffectual and disillusioning escapades and even unseemingly advances to members of the opposite sex, especially by older men. Such inappropriate expressions of instinctual urges and drives can be manifest when the individual's psychological defenses and repressive mechanisms break down in the face of organic or structural damage or overwhelming psychological stress. The inappropriate sexual advances of a tottering senile gentleman toward a young girl are generally on the basis of a breakdown of defensive and repressive mechanisms and do not have the same import as those of younger pedophiles, although they are likely to be viewed and dealt with legally in a like manner.

A study of 250 elderly persons who ranged from 60 to 93 years of age[3] revealed that elderly persons can be quite active sexually into the seventh, eighth, and even ninth decades. Of 149 subjects who were married, 54% were sexually active to some degree. The frequency of relations ranged from once every other month to three times a

week. Individuals who rated sexual urges strongest in youth rated them as moderate in old age, and those who rated them as weaker in youth were almost without sexual urges in old age. Most persons retain personal sex interest almost to the end of their lives.

The fears of older people concerning loss of genital potency seem in conflict with a cultural demand that they become asexual much in the way that the child was once thought to be sexless. Defense against declining sexual prowess can lead to behavior which results in guilt, fear, and anxiety. Sexual fantasies and masturbation may occur. Guilt over sexual desire may be expressed in symptoms which are not due to a specific organ disease or dysfunction. The physician should be atuned to the expression of concern over sexual feelings, have a fair amount of knowledge about the sexual habits and practices of old people which he can share with the patient, and be free enough of preconceived notions and prejudice that the older person will feel secure enough to discuss the subject with him.

One may reassure the patient by talking with him in a general way about the sexual difficulties and frustrations of people in his age group, universalizing the occurrence of these problems rather than talking with the patient specifically about his personal sexual conflicts. It may be appropriate to talk with him about his personal concerns if rapport is established and the physician is sure that he is not delving into conflictual areas or will be considered seductive by his aged patient.

It is well known and accepted that certain attitudes and behavior on the part of parents and society can cause regression, inhibit maturation processes, and drastically curtail the psychological development of children. Similarly, the aged person is sometimes subjected to attitudes which can cause regression and curtail the maximum effective and productive life-span of the individual. The older individual often becomes more dependent upon his grown children. The children should not overprotect and infantilize their aged parents but foster independent, adaptive behavior and responses. Generally, the physician should recognize and encourage the individual's innate desire to remain independent to the limit of his abilities.

Aged persons often are seen by the physician during a state of crisis when they need services in addition to medical management. This frequently places responsibility on the physician to arrange admission to a state or general hospital or other care-taking institution: referral for other types of services is frequently necessary. Therefore, he sees the patient at a time when he is unusually dependent; and it should be kept in mind that the same patient, when the immediate stress has been mastered, may be able to adapt more successfully to his environment. Perhaps the most helpful attitude for the professional person is concern about how to plan *with* the older person, rather than *for* him.

Progressive losses in the biological, intellectual, and social spheres, greater concern about health and awareness that one's time is drawing to a close are conducive to depression. In the geriatric age group depression and suicide are encountered more frequently although symptoms of depression often are not readily apparent. The patient may voice feelings of malaise or gradual loss of interest in his activities: somatic complaints may complicate the diagnosis. The physician often may elicit expressions of concern about the future: the patient may describe a recent traumatic event or loss which he relates to his despondency.

The doctor's appreciation of the patient's difficulties and willingness to be of service generates a feeling that all is not lost. With the establishment of rapport and reassurance that the doctor is willing to gratify the patient's needs, symbols such as medicine and other forms of treatment serve as tangible evidence of the physician's interest. This therapeutic orientation tends to counter the aged person's feeling that his resources—personal, environmental and emotional—are slipping away from him.

The patient whose depression begins to interfere with the performance or enjoyment of his normal activities may benefit from one of the antidepressant compounds. A new drug, nortriplyline hydrochloride, seems to cause less frequent and milder anticholinergic side effects than related compounds. It should be started in low dosage and gradually increased to a maximum of 100 mg daily. A significant number of aged people experience mild anxiety or agitation during the day and difficulty sleeping at night. These symptoms may be found in depression and organic brain syndrome.

They may wander restlessly about their home, disturbing other family members. Thioridazine hydrochloride (Mellaril) in doses of 10 to 25 mg several times a day or at bedtime may be helpful in such cases. Usually a responsible family member can regulate the dosage in order to obtain the desired sedation. This avoids long-term treatment with the barbiturates or other habit-forming sedatives. The minor tranquilizers are useful in the treatment of mild anxiety reactions and tension states: the indications are similar to those found in the younger age groups.

An appreciation of cultural influences on the relationship between the physician and his patient, of one's own personal bias toward the aged person, and cognizance of the peculiar changes in the relationship of the older person to his environment are important in establishing and maintaining the most effective relationship with the geriatric patient. His concerns about loss of personal resources and his frequent subjection to regressive pressures are potent influences with which the physician must reckon.

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WISCONSIN'S HEALTH by E. H. JORRIS, M.D., State Health Officer

MANY HEALTH WORKERS ENTER BATTLE ON PKU

Routine conformity with Wisconsin's so-called "PKU law" set off a chain of events a few weeks ago that illustrates how various segments of the public health team work together to serve the people. The PKU law is a statute, passed in 1965, that makes the attending physician responsible to see that each newborn infant is tested for phenylketonuria (PKU).

A blood sample for PKU testing was taken four days after birth from an infant born Aug. 2 in a hospital in southwestern Wisconsin. The sample was sent on to a nearby hospital laboratory certified by the Division of Health to perform PKU tests. On Aug. 12 the sample was tested and indicated possible PKU.

This result was reported to the Division of Health on Aug. 14 and the staff immediately contacted the physician who had attended the birth and offered assistance. A second blood specimen was taken and sent to the Division of Health at Madison. The repeat test supported the initial indication of possible PKU.

On Aug. 17 the attending physician asked the County Public Health Nurse to personally contact the parents of the infant, explain the seriousness of PKU, and arrange to have them bring the infant to specialists at the University Hospitals for further study. The baby was brought to Madison and a series of tests confirmed the diagnosis of phenylketonuria. The infant was placed on a diet of Lofenalac, a special dietary material that is furnished by the Division of Health. The special diet regimen is usually needed for 6 to 8 years. By Aug. 21 the infant was at home and on a diet which will permit the baby to develop in a normal manner free from mental retardation.

Wisconsin's PKU screen testing law became effective Jan. 1, 1966, and during that calendar year a total of 82,301 screening tests were made. There were 61 infants whose tests indicated a need for further checking and 8 were confirmed as PKU. The remaining 53 infants with suspicious first tests were found to be infants with immature enzyme systems who later tested as normal, or infants with other non-PKU abnormalities.

In the first 6 months of 1967 there were 36,050 infants tested for PKU and 36 indicated a need for further testing; all 36 were subsequently found to be non-PKU. Since July 1, 1967, three newborn infants and one 2-year-old child have been diagnosed as having PKU. All of these children are now receiving the special diet.

The Division of Health is notified of every suspicious blood test and follows each suspected PKU case through final diagnosis and beyond. A register of all known PKU cases is kept and progress is checked regularly. Each case of potential mental retardation discovered and placed under treatment can represent a substantial financial saving, but no one can place a price tag on a healthy, alert youngster.

Neurologic Problems of the Aged

By FRANCIS M. FORSTER, M.D., Madison, Wisconsin

■ IN THIS MODERN DAY of obsolescence, when household appliances are so constructed as to have a life expectancy of about five years, it is not at all surprising to find that the Architect of the human body had long anticipated obsolescence. In that great master tissue of the human body obsolescence was a built-in factor. Interestingly enough, some of the obsolescence occurs long before delivery; for example, the notochord, which served its purpose not too long after closure of the neural groove, remains only as an occasional cause of an insignificant anomaly of the bodies of the vertebrae, or the few vestigial cells seen on histologic examination of the intervertebral discs. However, in the neurology of the aged we fully understand that this study of obsolescence is considered from a nonprognostic viewpoint.

The neurologic diseases of aging may be classified as (1) those peculiar to old age; for example, the senile dementias, (2) those occurring in old age as well as other periods of life; for example, infections, and (3) those occurring in other epochs of one's life expectancy but occurring more frequently with increasing age, such as cerebrovascular disease. The clinical aspects of this can be approached from the standpoint of the presentation of symptoms, with reasoning back toward an etiologic and pathologic process.

In the Bard's seven ages of man (from *As You Like It)* . . .

"the sixth age shifts
Into the lean and slipper'd pantaloon,
With spectacles on nose and pouch on side,
His youthful hose, well sav'd, a world too wide
For his shrunk shank" . . . he reflects upon the normal atrophy of age. Sometimes this masks a pathologic process because the patient too readily ascribes the wasting muscle tissue to the common knowledge of normal senescence. A disease process may be overlooked, such as amyotrophic lateral sclerosis with its peculiar panvoluntary motor system involvement including anterior horn cells, counterparts in the medulla, and the cranial motor nerve nuclei such as the nucleus ambiguous facial and hypoglossal nuclei. The continuous degeneration of the anterior horn cells brings about the loss of normal state of the muscle, or the atrophy of the muscles, while the concomitant degeneration of the cortico-spinal system, from Betz cells to anterior horn cells, produces the complexities of the pyramidal tract signs of hyperreflexia and spasticity, positive plantar signs, and finger signs. The severity of these pyramidal tract signs is dependent upon the severity of the anterior horn cell disease at particular levels for the anterior horn cells, being the final common motor pathway, when severely involved erase the symptomatology of the cortical spinal tract. While the senile wasting of muscle in itself is not alarming, a combination of fasciculations and hyperreflexia as well as spinal tract and bulbar signs make the presence of this disease likely. A word of caution is necessary in the interpretation of the presence of fasciculations. These obvious muscle twitchings occur to a reasonable degree in normal subjects, especially in the gastrocnemius muscle.

Weakness in old age is a common complaint with the experience of passing through each decade with less ability to pursue the vigorous activity of the preceding decade. Weakness, however, may be pathologic; in this regard it is important to remember that myasthenia gravis occurs in the older age group in the male, being most common in the 50s and 60s. Another peculiarity that can be recalled is that the characteristic variations in weakness and change in nature of it may not occur in all cases, most particularly when the myasthenia affects the extraocular muscles. The use of edrophonium bromide (Tensilon) and neostigmine bromide tests plays a very definitive role in this differential diagnosis in these conditions.

Presented at Symposium of "The Geriatric Patient" under auspices of the Division on Nervous and Mental Diseases of the State Medical Society of Wisconsin and others, Eau Claire, Wis., April 5, 1967.

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Still directing our attention to motor phenomena of a relatively mild, insidious onset, the "slowing down" of age may be confused with the early symptoms of Parkinsonism. While Parkinsonism until several decades ago was more common in the younger age group, with the passage of time and the fortunate absence of an influenza epidemic and cases of Parkinsonism in the younger age group, the etiology now is primarily on the basis of arteriosclerosis or of the parenchymatous degeneration of the neurons in the basal ganglia, most notably the substantia nigra and in the globus pallatus. However, the exact location of the lesion in Parkinsonism is still a vexing problem, because of the widespread and diversity of locations of the lesions due to either of these causes. An important cause of the Parkinsonism syndrome in recent years is iatrogenic due to the administration of the phenothiazines. Peculiarly enough, these drugs can even produce the oculogyric crises formerly so characteristic of the postencephalitis cases.

The pathologic processes which involve the cerebral cortex and its projections to subcortical structures produce a variety of symptoms dependent, of course, upon the location of the lesion and the rapidity of the development of the pathologic process. One of the most outstanding of these symptoms is hemiplegia. The classic picture of hemiplegia consists of spastic paralysis of the arm and leg, increase in tone involving the anti-gravity muscles, hyperreflexia, and positive pyramidal tract signs. The weakness of the face is most marked in the lower face and involves the muscles of the tongue, and is usually of a minor to moderate degree. The peculiar sparing of the upper face and relative sparing of the tongue and laryngopharyngeal musculatures is dependent upon the providential degree of bilateral representation. These structures serve a purpose in the preservation of the integrity of the individual and hence are too important to have a unilateral cortical representation. While this is perfectly obvious for those muscles concerned with deglutition and respiration, the upper facial musculature is somewhat anomalous to be classified in this group. We must remember that the nervous system was laid down in the primates and lower species for quadrupedal existence. The role of upper facial musculature was important in the alerting reflex for them in the avoidance of predatory foes. The weakness in hemiplegia is most marked in those muscles with the greatest cortical representation. In the extremities, these are the muscles employed in moving the digits. While our proverbial sayings are usually quite accurate physiologically and anatomically, the old saying regarding clumsiness that one is "all thumbs" is certainly a misnomer. The thumb has the greatest versatility of function and the greatest cortical representation, and it probably would be an asset to be "all thumbs." The thumb and fingers are vitally involved in hemiparesis.

Hemianopia, or loss of vision to one side, most commonly is not associated with macular involvement and, for this reason, may be less evident to the patient. However, even with the presence of macular involvement, hemianopia might not be appreciated by the patient. This is especially so if the hemianopia involves the right visual fields, since it is in the process of reading that one encounters the greatest difficulties. With left hemianopia, patients have difficulty in finding the left margin of the page in order to begin reading, and their continuity of thought content is lost in incompletely perusing the paragraphs.

The occurrence of hemianesthesia indicates the lesion is at or below the thalamic end stations of the spinal-thalamic tract, namely, the posterolateral ventral nuclei. Lesions above that point no longer cause a complete hemianesthesia. There is then slight impairment of pain sensation, but higher cortical sensory losses occur—impairment of texture, weight discrimination, pinprick localization, stereognosis, and bilateral and simultaneous sensory perception. Although obviously not as debilitating as hemiplegia, sensory loss in some patients may present a picture of incapacitation to almost the same degree. These patients on a peculiar pseudo-athetoid movement, presumably to bombard the central nervous system with a sensory input, and may require sensory rehabilitation and training.

The use of language for communication is peculiar to us humans, the highest representatives of the primate group. While animals can communicate certain signals to each other, there is no reason to believe that any real abstract communication is possible except in the human. The human has devel-

oped a system of symbolic communication, both verbal and written, employing the connections and synapses between various cells in the brain to develop a pattern for data collection and retrieval. A destructive lesion involving this network makes it impossible to either collect or retrieve data. A problem in data collection is the sensory type aphasia wherein the patient cannot monitor the input and cannot perceive or understand what he hears, nor can he recognize the commands and incoming material. From the retrieval standpoint there are two possible difficulties. One is the inability to express himself albeit he has a complete understanding abstractly and as to nomenclature but cannot express the words.

A common type of aphasia is the amnestic type, and here the data retrieval is impossible because the patient, while he retains concepts, cannot attach the words to the concepts so that he can express himself properly. Interestingly, patients have often found ways to circumvent this. Recently at the University Hospitals, we had a patient, with marked aphasia, whom I presented at Neurology Grand Rounds. Some of my colleagues said, "Well, what is so unusual? He is a classic example of aphasia, so why are you presenting him and what's unusual about him?" The answer was that he was an auctioneer and the interesting thing about him is that he can hold up an object and use the terminology of the sing-song jargon of the auctioneer and point to the person whose hand is up and make a sale without being able to name the object, although he is fully aware of what it is and of its intrinsic value. He could, of course, take his cues on the financial arrangements from the bidders.

Seizures developing in later life always raise the question of symptomatic epilepsy and its specific cause. Seizures such as petit mal do not occur in the older patients; the minor spells and what are sometimes erroneously called petit mal are either temporal lobe seizures, particularly psychomotor seizures, or partial seizures or other minor focal seizures. A minor focal seizure, for example, can be an episode of aphasia. A partial seizure, for example, could be the aura or onset of a major seizure beginning in one part of the brain. An example of this would be in a patient who has an auditory aura of tinnitus, followed by the hearing of specific sounds or music, head-eye deviation or lip smacking prior to entering into a classic psychomotor or typical major motor seizure. The seizure which aborts at the aura or the head-eye deviation component is oftentimes construed as a petit mal which, of course, is a misnomer since these are strictly focal seizures and not centrecephalic seizures as are petit mal.

What are the etiologic factors and pathologic lesions which produce these symptoms? Cerebral involvement, of course, can be due to any process which leads to or has led to destruction of brain tissue. In the older age group, the most common are cerebrovascular disease and neoplasms; the sequelae of head injury is less common in the older age group. The older one becomes the less one is exposed to the head injuries; and, of course, head injuries sufficient to produce this amount of symptomatology are quite obvious. There is an exception to this, and that is subdural hematomas, which very often may be due to relatively mild injuries. I recall one patient, a band director, who vigorously denied any head injury, and we were very concerned that he might have a brain tumor. We were relieved to find, after a neurosurgical procedure in which the dura was exposed, the turgid, tense, bulging dura of a subdural hematoma. The patient subsequently admitted—after being confronted with the evidence—to a head injury he had suffered during a rather vigorous bow in response to applause one evening when his orchestra had performed particularly well. He had inadvertently bumped his head on the bell of a tuba, and this apparently was the traumatic episode leading to the subdural hematoma. Subdurals are more common in middle and older life than they are in children.

In the adult, cerebrovascular disease may be the result of inadequate blood supply to the brain. This inadequacy may be due to an actual thrombosis (although this is not nearly so common as thought earlier) or embolus. Since many of the episodes of infarction or encephalomalacia are associated with decreased activity such as sleep or oftentimes with episodes of body chilling and pooling of blood, they may be due to the failure to maintain a sufficient blood flow past an atheromatous plaque. The past several decades have made us all aware of the importance of the great vessels of the neck

as the site of the offending lesions, both thrombosis and plaque formation.

In cerebral hemorrhage there is a massive outpouring of blood into the substance of the brain, producing progressive destruction, particularly over relatively short periods, hours or days, of a large portion of the hemisphere, rupture into the ventricular system, and demise.

Venous sinus thrombosis is a disease primarily of children and younger adults and, indeed, with better attention to fluid balance and metabolic situations, this has become rare even in the younger age group. This may occur in older patients, however, with polycythemia. Peculiarly enough, massive anomalies of the cerebrovascular system may remain occult until the fifth or sixth decade, then present with a catastrophic onset. On the angiography, this demonstration of large, arteriovenous aneurysms is surprising. The cerebral symptoms may, of course, also be due to neoplasm. The primary neoplasms are not common in the older age group, but tumors, and especially glioblastomas, do occur in the older age group. The course of these is relatively rapid and may cause considerable confusion in the differentiation between the vascular disease and the neoplasm. Of the tumors, however, the metastatic are of great concern, since they are more common in the older age group.

Since the overall tenor of this symposium is primarily psychiatric, I have deliberately kept for last the consideration of the organic mental syndrome which Marcus Tullius Cicero described so well in his essay *De Senectute* (on old age)—"quo vobix mentis, rectae quae stare solebant ante hac, dementes sese flexere viai?"—which can be freely translated as "on what wild course have wits, once true, but worthless now, misguided you?" While organic mental syndrome as such was recognized in antiquity, we more sharply characterize it now as memory defect, most marked for recent events, often with preservation of remote memory, since patients cannot recall that they came in the hospital yesterday or what they had for breakfast, but can give you the name of their eighth grade teacher.

Associated with this are changes in affect, so that a previously irritable person becomes affable, and vice versa. Judgment is impaired; this is noted in business dealings, as mental ability is grossly impaired. The appearance of the organic mental syndrome in its insidious state immediately raises the question of the development of a senile dementia or dementia with cerebral arteriosclerosis. This is largely a semantic differentiation. It is difficult, indeed, clinically to make a differentiation. In the absence of a history of specific vascular accidents or appearance of ischemic episodes, it is customary to make the diagnosis of senile psychosis rather than arteriosclerosis. A frequent cause in earlier years for the organic mental syndrome was general paresis as a tertiary form of parenchymatous neurosyphilis involving the cerebral cortex as well as other structures. At the present time this is rather uncommon. It behooves us to remember that we may be in the several decades where this disease has virtually disappeared, thanks to the development of penicillin therapy. It is important to recall that we may see this disease again and perhaps in an unmitigated form as the cases of primary syphilis increase and as a certain diffidence develops in patients, perhaps even in physicians, for the vigorous treatment of the primary disease.

Neoplasms of the central nervous system may be the cause. We studied an elderly spinster school teacher from a small rural community. For the first time in her life she became involved in an illicit love affair with a married, prominent member of the community. This led to her having to leave the community, because of her poor judgment, not only in engaging in the affair but also in not being discreet in her disclosure of it. She was apprehended by the state police, while driving to another community to begin teaching there, because she was driving on the wrong side of the road. She was thought to be hysterical because she complained of being blind, but on gross examination her fields were full. She presented what one might call la belle indifference. During the neurologic examination it became apparent that she actually had a field defect which she was covering by surreptitious eye movements, so that when tested on the perimeter without careful observations of her extraocular movements, she had been able to obscure the fact that there was an impairment of visual fields. The neurologic examination further disclosed anosmia. On angiography she was found to have a large olfactory groove meningioma which had

interrupted the fibers of the olfactory bulb to the cribiform plate, had impinged upon her optic nerve, and had produced a bilateral frontal lobe compression with the subsequent and consequent development of organic mental syndrome. Tumors within the parenchyma of the nervous system, such as glioblastoma, may likewise produce these signs. Ironically, but fortunately seldom, the cerebellar neoplasm such as the hemangioblastoma may compress the fourth ventricle and cause ventricular dilatation, thus presenting an organic mental syndrome.

In conclusion, perhaps the most significant factor in dealing with the neurology of the aging population is the development of suspicion at those signs and symptoms natural in themselves within certain limits when the indications of normal senescence be appreciated. The extent, location, or sequence indicates that they are the result of a pathologic process rather than of normal aging. This is followed by the judicious use of diagnostic means within the realm of safety indications for the individual patient so that proper therapeutic principles can be outlined to maintain our aging citizens' nervous systems in as young as possible a state.

Psychiatric Morbidity of Physicians

JOHN C. DUFFY, MD and EDWARD M. LITIN, MD, Mayo Clinic and Mayo Foundation, Rochester, Minn.: *JAMA* 189:989–992 (Sept 28) 1964.

These are the duties of a physician: First . . . to heal his mind and to give help to himself before giving it to anyone else.

—Epitaph of an Athenian Doctor, 2 AD

PHYSICAL ILLNESS in the nation's physicians has been the object of a number of recent investigations. For the most part, they have emphasized the need for annual comprehensive medical examinations, particularly with regard to pulmonary function and cardiovascular status. Virtually no studies have been made of psychiatric illness in physicians, the only exception having been in the specific area of drug addiction.

The overall health evaluation of physicians is incomplete without a consideration of psychiatric illness. This paper reports the authors' experiences with a significant number of physicians whose emotional illness required hospitalization.

From 1956 through 1963, 93 physicians were admitted to the inpatient psychiatric service. The spectrum of psychiatric illness in the group included organic brain syndromes (uncommonly), psychoses, psychoneurotic disorders, and personality pattern disturbances; alcoholism and drug addiction were fairly common. The physician–patient group is representative of the distribution of physicians by practice in our present-day society. Treatment in most instances consisted of psychotherapy, medication, and a supportive environment; electroconvulsive therapy was used in 18 cases. The group was analyzed for a variety of trends and an effort was made to explore the general psychodynamics of the findings.

Presented at Symposium of "The Geriatric Patient" under auspices of the Division on Nervous and Mental Diseases of the State Medical Society of Wisconsin and others, Eau Claire, Wis., April 5, 1967.

With the swell of recent government and public interest in mental illness, it becomes imperative for the medical profession to assess its own mental health. Physicians of all disciplines will be expected to assume a primary role in the overall management of psychiatric patients in the general population. This expectation automatically and justifiably involves the assumption that physicians will be generally an emotionally healthy group. But, is this true?

Our society is becoming increasingly sophisticated in medical matters as a result of medical advances and the widespread dissemination of information about them in the communications media. Because of the demands on the physician's time and knowledge, he constantly feels threatened, not only by his patients but also by his colleagues, to maintain his professional competence. In addition, he is expected to fulfill his obligations as a husband, father, and civic leader. The resulting demand that he be all things to all people is a potentially strong propelling force in the direction of emotional decompensation.

Physicians need to exercise enlightened compassion with regard to mental illness in their fellow physicians. In the close fraternal ties of the profession, serious emotional illness in a physician soon becomes apparent to all. It would seem that in our group there is a general reticence on the part of other physicians to intervene in the situation, as well as a tendency to be "overprotective" of the involved individual.

We regard the study of psychiatric ills of physicians as a preliminary step in the direction of a better understanding of emotional illness as it affects a selected group of individuals and hampers their productivity.

The medical profession must be willing to deal directly with the problem of psychiatric illness among physicians, have the courage to diagnose it accurately, and acquire the understanding which must support the physician who returns to the community after "the anguish and folly of madness."

CASE REPORT

The Geriatric Patient

By ROBERT N. LEASUM, M.D., Osseo, Wisconsin

■ THIS CASE WAS selected for presentation because it demonstrates two of our more difficult and common problems. These are the neurologic disorders which often are masked by the psychiatric manifestations that frequently are seen in the geriatric patient, and the difficulties involved in persuading the elderly patient that nursing home care has become essential because of his illness. Our group of three doctors is responsible for the care of 180 nursing home patients in three local communities. In addition, our practice has an exceptionally high incidence of elderly people because of the problems that are facing an agricultural area at the present; namely, the inability of younger age groups to obtain satisfactory farm incomes and because of this, a shift of the younger people to urban areas.

A recent survey by the State Board of Health indicates that our particular area has approximately two times as many people over the age of 65 as most other areas of the state. Because of this situation, we frequently are dealing with rather bizarre problems and cases.

The case selected combines both a neurologic disorder and the psychiatric problems of advancing age. I first saw this particular patient in August 1965 at his home. He had farmed all of his life and, with his wife and an elderly sister, had lived on the same farm for 80 years. The patient and his wife had no children and had outlived all but a few distant relatives. These three people had managed to care for themselves quite well until approximately six weeks prior to this house call. Neighbors had informed me on several occasions that they were having difficulty caring for themselves properly and the husband particularly had become confused at intervals. All three of these patients were in their eighties.

The farm house was an ancient building in need of major repairs. A large sheep dog met me on the walk to the house looking as if he were going to attack at any moment. However, his first growl was only an attempt and I could see that he was edentulous and arthritic; a number of chickens were strolling through the house and onto the porch. A partially consumed meal was left on the table. One large rooster was pecking on a bowl of potatoes sitting next to the entrance. The patient and his wife were both in the only other usable room in the house—the bedroom.

He stated that he had become very dizzy the day before and had fallen. Since that time he had complained of weakness and vertigo. There was no evidence of trauma but it was difficult to move him about because of his advanced degenerative joint disease. His initial blood pressure was 180/100 mm Hg; the cardiovascular status was essentially normal for his age.

Because of the inability of all three people to care for themselves as demonstrated by the obvious hygiene problems, I suggested that they should consider a nursing home. This was of course rejected immediately. Aside from the elevated blood pressure of the husband, I could find no other obvious reason except perhaps the arteriosclerotic factor obvious at his age.

After leaving the farm, I notified the county health authorities of this particular problem but they were unable to help because the people were considered legally competent. Approximately one week later I was called again to see the patient at his home. He had fallen again and was lying on the floor when I arrived. His wife stated that he had rested in bed for several days after my previous visit but during the past 48 hours he had complained of increasingly severe headaches.

Examination disclosed a right facial weakness, a right hemiparesis, a dilated left pupil, bilateral Babinski signs, and a left ankle clonus. He was conscious but not oriented as to time or place. He was brought to our local hospital with a tentative diagnosis of cerebral vascular accident. Initially I felt that

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this represented a rather typical "stroke" patient. However, he quickly demonstrated more evidence of progressive disease with loss of consciousness.

A lumbar puncture a few hours after admission disclosed a xanthochromic spinal fluid with 272 mg/100 ml protein. He was transferred to the neurosurgical section of the Mayo Clinic because of the somewhat unusual neurologic picture as compared to most typical cerebral vascular accidents.

A bilateral carotid angiogram was performed and a large right subdural hematoma was demonstrated. It was immediately evacuated through burr holes in the right frontal, temporal, and parietal areas. He regained consciousness five hours postoperatively but had residuals of a right hemiparesis and some confusion for two weeks.

Six months after surgery the patient was completely lucid and it was obvious to his neighbors that he was very alert and was again taking interest in his farm. In spite of his age, he was making attempts to repair his home. I recently talked to this patient in my office and he recalled my discussion concerning nursing home care. He informed me that he would consider this only when he became older. It was my impression that many of his complaints prior to his hospitalization could have been due to the presence of a chronic subdural hematoma and were not a manifestation of the aging process alone.

PATHOGENESIS OF THE SPORADIC CASE OF TUBERCULOSIS

WILLIAM W. STEAD, MD, Milwaukee County General Hospital, Milwaukee, Wis.: *New England Journal of Medicine* 277:1008–1011 (Nov 9) 1967.

Data are presented to indicate that pulmonary, like other forms of tuberculosis in the adult, is largely the result of delayed development of disease from the primary infection and not of a subsequently acquired reinfection. Tuberculin reactors should be followed with periodic roentgenograms for life because only in this way can late development of disease be detected before it produces undesired pulmonary destruction and environmental contamination.

Most cases of chronic tuberculosis occur in tuberculin reactors who have no knowledge of having had the infection in the past and in whom there has been no recent exposure to the infection. The practical implications of such a "unitary concept" of tuberculosis and the need for reexamination of some of our guiding principles of tuberculosis control are discussed. The role of residuals of prior infection is strongly suggested by the frequency of apical scars existent for years before emergence of clinical disease.

NEW IMMUNIZATION GUIDE FOR ADULTS

Publication of a new working manual for doctors and other health personnel on the subject of immunizations for adults has been announced by the American College Health Association (ACHA).

The 55-page, spiral-bound booklet entitled *Adult Immunization Guide* describes immunization procedures for some 19 infectious diseases. It was prepared by the ACHA's Committee on Immunizations and printed under a grant from Lederle Laboratories Division of American Cyanamid Company.

Commenting on the new publication, ACHA President Dr. Donald L. Cooper said: "While good references are available for immunization of infants and children, this new booklet provides the medical profession with clear and concise guidelines for immunization of adults against infectious diseases. It is an attempt to give practical and workable explanations regarding many unsettled aspects of immunizations." Dr. Cooper is director of health services at the Oklahoma State University in Stillwater.

Information on how to secure copies may be obtained by writing the American College of Health Association, Box 9117, University of Miami Branch, Coral Gables, Fla. 33124.

GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT—THE REPRODUCTIVE AND URINARY SYSTEMS

The eleventh guide in the series, "Guides to the Evaluation of Permanent Impairment," developed by the AMA Committtee on Rating of Mental and Physical Impairment, is available. It is entitled "Guides to the Evaluation of Permanent Impairment—The Reproductive and Urinary Systems." Although this guide, like all the others in the series, has been designed primarily for use by physicians, it is of interest and use to all concerned with the medical, administrative, or judicial aspects of programs for the disabled. The previously published guides in the series deal with the extremities and back; the visual system; the cardiovascular system; ear, nose, throat, and related structures; the central nervous system; the digestive system; the peripheral spinal nerves; the respiratory system; the endocrine system; and mental illness.

The guide has been recently published in *JAMA*. A limited number of copies of this guide may be obtained, without charge, upon written request to the Committee on Rating of Mental and Physical Impairment, 535 North Dearborn St., Chicago, Ill. 60610.

Therapeutic Dilemmas

No. 4 of a Series

Editor:

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COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner periodically in the WISCONSIN MEDICAL JOURNAL.

PRIMARY MYOCARDIAL DISEASE

Moderator: DAVID C. MOUNTAIN, M.D.

Participants: WILLIAM CORCORAN, JR., M.D.
FRANCIS F. ROSENBAUM, M.D.
NORBERT ENZER, M.D.
RAMON L. LANGE, M.D.

Dr. David C. Mountain: This morning's very interesting case is being presented under the title of "primary myocardial disease," but you will learn, as the discussion advances, that the entity has several other names as well as some confusing aspects. Primary myocardial disease seemed to us the simplest if not perhaps the most accurately descriptive title for the conference. Doctor Corcoran will present the protocol.

Dr. William Corcoran, Jr. (Resident in Medicine) : This patient, a 51-year-old white man, at time of admission to the hospital in January 1967, ascribed the onset of his difficulties (with the exception of a 45-minute episode of substernal pain in 1953) to a flu-like illness in January 1960, which was followed by profound fatigue and a dragging sensation in the chest. In March of that year, cardiomegaly, some neck vein distension, and gallop rhythm with electrocardiographic (EKG) evidence of a discordant bundle branch block had been observed. (An EKG in 1953 was normal). There was shortness of breath at that time, paroxysmal nocturnal dyspnea, cough and palpitations on exertion. He was placed on digitalis and diuretics. In July, the Mayo Clinic confirmed the working diagnosis of a probable viral or idiopathic myocarditis. In August, there was a syncopal episode after prolonged standing and speaking at work, and by December he was requiring 10 to 11 hours sleep nightly and several naps during the day. He was then working, as a manufacturer's representative, only several half days weekly.

In October 1962, he was said to have had some evidence of renal disease and to have been given penicillin. In March 1963 he entered this hospital in acute left ventricular failure, which responded well to usual therapy, but he continued to be extremely fatigued after discharge. In August 1965, the patient was admitted to Mt. Sinai Hospital here in Milwaukee with increasing respiratory difficulty. At this time the liver was found to be enlarged, there was a chronic, purulent and tenacious postnasal drip, and his weight had gone down from 170 lb to 145 lb.

At a second admission to Columbia Hospital in January 1967, he was found to be acutely ill, with dusky pallor, diaphoresis, and distended neck veins. There was marked cardiomegaly, generalized wheezes and râles, a diffuse gallop rhythm, and a pansystolic blowing murmur at the apex and into the left axilla. The liver was palpable about 2 cm below the right costal margin and there was slight pretibial edema. The blood pressure was 100/70 mm Hg. The only distinctly abnormal laboratory findings were a slightly elevated blood urea nitrogen (BUN) and some casts and fat droplets in the urine. X-ray films of the chest disclosed only marked congestion and cardiomegaly. Amyloidosis was considered, but a rectal biopsy was normal. EKGs on several occasions showed a discordant left bundle branch block and deflections of a magnitude suggestive of left ventricular hypertrophy.

Upon leaving this hospital after his second admission, the patient was admitted to Mt. Sinai Hospital for a second time, where he died after a few days.

Dr. Mountain: Doctor Rosenbaum, whose patient this was, will now discuss the case and the subject of primary myocardial disease in general.

Dr. Francis F. Rosenbaum: The principal features in the patient's history have been well covered by Doctor Corcoran. I would only add that as far back as 1960 there was a loud grade III systolic murmur, most intense at the apex. This murmur, although variable in degree, as was the heart size also, persisted throughout the entire illness. There was also a ventricular gallop in 1960, which persisted; and at the final admission to Columbia Hospital he also had paradoxical splitting of the second sound along the upper left sternal margin. In 1961 and 1962 there were episodes of syncope. I mention all these particulars because they are strongly suggestive of primary myocardial disease.

I shall now say something about the major clinical features that are helpful in making a diagnosis of this malady. Cardiomegaly is probably the hallmark, and this was prominent in our patient. Then there are all the manifestations of congestive heart failure and a wide variety of arrhythmias; indeed ventricular tachycardia may sometimes be the initial overt episode.

There is a wide variety of auscultatory features, especially atrial or ventricular gallops or both. If the two gallops are very close together there may be a confusing sound at the apex, like that of a diastolic rumble, or the two gallops may summate into one. Wide splitting of the second sound along the upper left sternal margin is very characteristic; one is likely to find a fixed splitting of the second sound if there is right bundle branch block, and paradoxical splitting if the block is of the left bundle branch. Various forms of heart block are encountered with characteristic auscultatory features. The occurrence of left bundle branch block in our patient nearly seven years before his death, and its persistence thereafter without much change, was one of the manifestations leading us to consider this diagnosis from the very outset.

Systolic murmurs are very common, usually representing mitral incompetence, but with increasing cardiac dilatation there may be tricuspid incompetence also, which is strongly suggested by increase in intensity of the murmur with inspiration. A diastolic sound like the diastolic shock of constrictive pericarditis is sometimes recorded. EKG features range all the way from nonspecific changes in the ST segments and T waves to various forms of intraventricular, particularly right and left bundle branch, block.

In my experience, primary myocardial disease is a diagnosis that is usually made by exclusion. Confusion with rheumatic valvular disease is lessened by the fact that in the latter the systolic murmurs tend to intensify as compensation improves, whereas in primary myocardial disease they become less intense as the failure responds to treatment. Systolic murmurs at the base, particularly in the aortic area, may be of the ejection type, especially in those forms of the malady in which there is hypertrophy and obstruction of the left ventricular outflow tract and the picture of so-called idiopathic hypertrophic aortic stenosis. Of course there may be confusion with pericardial disease, but whereas in constrictive pericarditis the increased venous pressure is unlikely to fall to more normal levels, it may do so in primary myocardial disease.

In a patient who has coronary arterial disease confusion is very easy, but I should say that, upon the whole, if one encounters a patient with cardiac enlargement, a relatively long survival after onset of congestive heart failure, no evidence of diabetes, no hypercholesterolemia, no clear history of angina pectoris or antecedent myocardial infarction or hypertension, then one should seriously consider a diagnosis of primary myocardial disease. The disorder may be confused with hypertensive vascular disease, but I would point out that in our present patient hypertension was never observed, and in his last years hypotension was a characteristic feature.

Dr. Mountain: Thank you, Doctor Rosenbaum. We are fortunate in having with us today Doctor Norbert Enzer, a member of our Consulting Staff, who is Director of Laboratories at Mt. Sinai Hospital and who has not only been a close student of this disease for many years but also can present the actual necropsy findings in the present patient.

Dr. Norbert Enzer: Those heart cases that do not fall into the well-established valvular, hypertensive, and arteriosclerotic classifications need constant restudy and revision, and from such detailed investigation the present malady has evolved as a sophisticated 20th century development in cardiac pathology. May I inquire regarding this morning's patient whether he at anytime had an escape

Figure 1

Figure 2

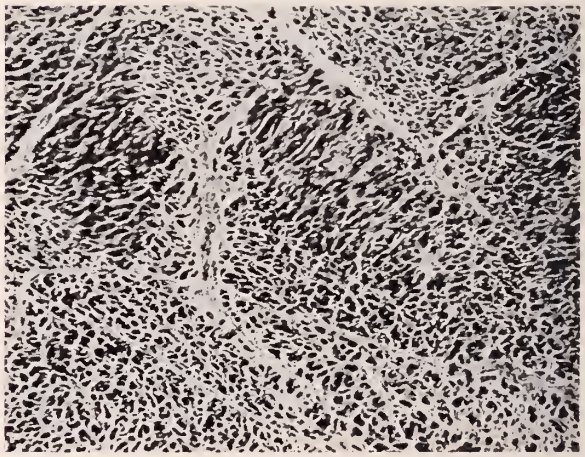

Figure 3

of fluid into the serous cavities—any ascites or pleural effusion?

Dr. Rosenbaum: No.

Dr. Enzer: He did not at necropsy either. This is one of the puzzling features, as I shall show. The heart weighed 730 gm and there was neither pericarditis nor pericardial adhesions. The epicardium was smooth and rather edematous with prominent, congested vessels. Figure 1 is an exposure of the left chamber, which is dilated and hypertrophied and with a tendency for the muscle trabeculations to fuse in the apical area; there is no evidence of mural thrombi despite the intense plexiform picture we have here lining the ventricle. Probably the essential feature in this case is revealed here on the surface of the interventricular septum: spreading downwards from the reflection of the valve at the top is a grayish opacity with some yellowish and stippled speckling or discoloration. There is a somewhat irregular margin to this thickening (or opacity) of the endocardium at the extreme left, where you see a knob-like formation of gray tissue and a disruption of the endocardium, which seems to be excavated or undermined. At the extreme margin of the left ventricle there appears to be a cyst-like formation, and as one approaches the apex the opacity and discoloration tend to disappear; it does not spread in a solid membranous fashion over the trabeculae. The same changes were seen in the right ventricle, but nowhere was there thickening or fusion of the valves although the rings were dilated in all instances. The lining of the atria was not affected.

There were no findings which could be equated with previous myocardial infarction; the coronary vessels were all patent and of good size and not significantly sclerosed. The liver was moderately enlarged with evidence of congestion of some duration; indeed this was almost a "shock" liver with not only vascular disruption but disintegration of liver cells as well, a finding compatible with fulminating congestive failure.

Figure 2 is a long section through the left ventricle and we note the muscle hypertrophy and peculiar crescentic thickening of the endocardium in the center of the field, fading out on either side. I call your attention to the dense dark zone of elastic tissue and the lighter staining material which is the connective tissue framework of the heart muscle. Elsewhere in the myocardium (Fig 3) the striation of connective tissue is widespread but there is never the kind of scar tissue formation characteristic of infarcted muscle.

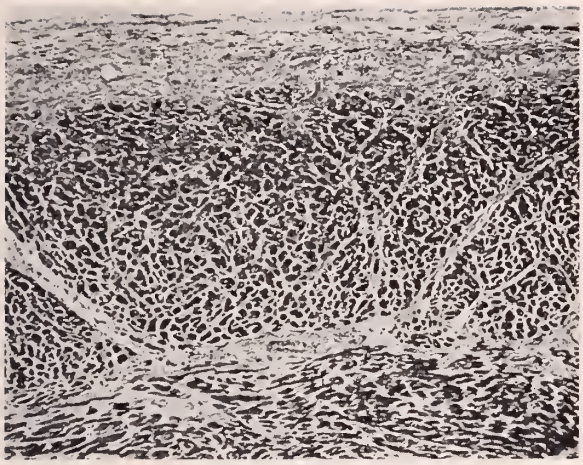

Figure 4

Figure 4 demonstrates a layering of elastic tissue on the free surface of the endocardium and the tendency of the fibrous tissue of the endocardium to extend in tentacular fashion into the underlying myocardium. Figure 5 is a papillary muscle so completely surrounded by fibrous tissue that it has ceased to be a free-functioning unit.

About two years ago we encountered a case similar to the present one: cardiomegaly; no sign of active myocarditis; no relationship with arteriosclerosis, hypertension, or coronary disease. The pathologic findings were somewhat at variance with those of our present case, however, in that there was bundling of the elastic tissue, marked distortion of the endocardium, and replacement of the myocardium in broad areas by scar tissue.

Is there any possibility that our present patient may have lived in Africa for awhile?

Dr. Rosenbaum: No.

Dr. Enzer: I ask because this disease, or group of diseases, first came to attention as a peculiar endomyocardial fibrosis in Africa, and was reviewed again in the current issue of the LANCET (I. F. Brockington et al. LANCET 1:583, March 18, 1967). The cause of this peculiar transformation of myocardium and endocardium is not established. Its alleged association with the eating of plantain, in the African cases, has been pretty well discountenanced. Viral etiology has been suspected, and the fact that there is a peculiar epidemiology in the African cases—preponderance in hot, humid areas—engenders thoughts of vector transmission. However, several cases of what might be designated the African type have been reported in British residents who had never lived in Africa.

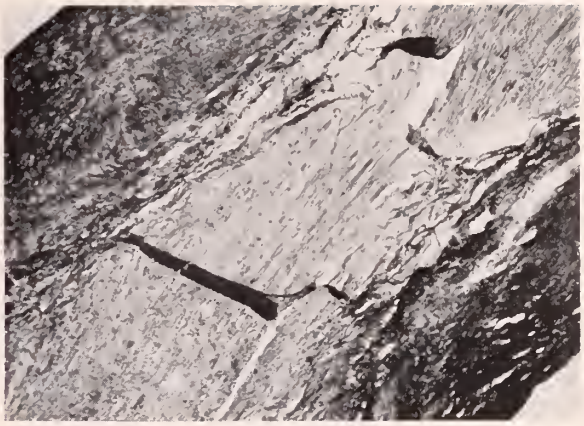

Figure 5

The malady may be related to other forms of endocardial fibroelastosis, such as may be seen in infants and children as well as in adults; many of the latter are, however, generally regarded as congenital or developmental.

We have now seen four cases of whatever this may be, including the one today. One of these I reported in 1935: a sudden death in a young man, in whose heart there was a sheet-like grayish membranous thickening of the endocardium overlying a tremendously hypertrophied myocardium. Doctor Maud Abbott, who studied the case, thought it was some form of congenital cardiomegaly. One of the other cases was confused with rheumatic fever because of mitral valvular distortion; we now know that the endocardial fibrosis in what we are calling this morning "primary myocardial disease" may spread up and cover both the mitral and the tricuspid valves, although involvement of the pulmonary and aortic cusps has not been reported.

Dr. Mountain: Thank you, Doctor Enzer. We are privileged to have with us this morning Doctor Ramon Lange, Professor of Medicine in the Department of Cardiology at Marquette University and the Milwaukee County General Hospital, who will continue the discussion.

Dr. Ramon L. Lange: From the therapeutic standpoint it is most important to attempt early differentiation between obstructive and nonobstructive myocardiopathies because palliative surgery can now be performed in the obstructive cases. Time does not permit recapitulation of most of the points that have already been made; however, the physical findings are the results of alteration in ventricular compliance (prom-

inent A waves and gallop sounds). An important point, then, in relation to diagnosis by exclusion (which is the ultimate guide to therapy) is that there is a type of patient, who may be anywhere from adolescence to advanced age, who exhibits heart failure, has disorders of electrical conduction, and perhaps a degree of atrioventricular block, but also has unusual physical findings which differ from the nonobstructive myocardiopathy. There is an ejection sound in early systole but sometime after the opening of the semilunar valves; there is a systolic murmur and to palpation there is a prominent atrial component. But more definitely there is a doubling of the apical impulse.

I have in mind a patient in whom the diagnosis was suspected at the bedside because of the combination of wide pulse pressure, extremely vigorous pulse wave, and the unusual broad and widened precordial and apical impulse. This patient had been in heart failure for some time and had been considered to have aortic valvular regurgitation as her primary disorder. She did have calcification of the ascending aorta, but her wide pulse pressure was due to the extremely vigorous ejection from the left ventricle, beginning with the first sound and being cut off at the mid- or early-systolic sound. This is the picture of idiopathic hypertrophic subaortic stenosis, to which Doctor Rosenbaum referred, in which the hypertrophy, while involving the ventricle in general, is concentrated in the subvalvular area so that the initial portion of ventricular contraction is very forceful, giving evidence of extremely good ventricular function.

A Physician: I should like to ask Doctor Lange what the tissue pathology is in hypertrophic subaortic stenosis?

Dr. Lange: The pathologic differences correspond to the functional differences. Though there may be an element of fibrosis, the distinctive feature is generalized hypertrophy but with special localization in the outflow tract of the left ventricle. Sometimes there is right ventricular hypertrophy also, which is usually explainable on the basis of the increased pulmonary artery pressure; however, there have been instances in which the development of outflow obstruction from the right ventricle in late life was an expression of this disorder in both ventricles.

A Physician: There is a group in Canada who are using beta-adrenergic blocking agents in subaortic stenosis to lessen the inotropic (muscle-stimulant) fraction of sympathetic stimulation in the ventricles, with the claim that some patients are being carried for a long time in this way without surgery. Could Doctor Lange comment on this?

Dr. Lange: We are aware of this approach, and have sometimes availed ourselves of a deliberately opposite maneuver for diagnostic purposes; that is the giving of isoproterenol (Isuprel). Our limited experience with the blockers in patients with milder forms of obstructive disease indicates alteration in ventricular force during exercise but not at rest.

Dr. Enzer: I would like to emphasize that in the group of myocardiopathies we are considering, most investigators consider that the damage is primarily in the myocardium. We are using the term primary myocardial disease, but the African cases are being split off as "endomyocardial fibrosis." And you saw in the illustrations that the disease can be apparently initiated in the endocardium. Of course the elastic tissue of the endocardium may be distorted in several processes: we see bundling of it in infarction, in infective endocarditis, in mural thrombosis, and the like. In elastosis of infants, which is called endocardial elastosis without fibrosis, the development abnormality of elastic tissue forms a heavy multilaminated layer. But in primary myocardial disease there are the gradations of fibrosis that I pointed out: an upper completely hyalinized layer, the middle layer fibrillated, and the inner layer fused with the myocardium by both connective and elastic tissue.

Dr. Mountain (summarizing): In the conference this morning we have had a general discussion of primary myocardial disease by Doctor Rosenbaum, an exposition of the malady's pathologic features by Doctor Enzer, and a presentation by Doctor Lange of the features differentiating hypertrophic subaortic stenosis, a surgically treatable malady under some circumstances, from the other forms, which are unfortunately not very amenable to therapy.

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IN ITS 165 HOSPITALS, six independent outpatient clinics and three outpatient clinics where no VA hospital is located, the Veterans Administration employs 16,000 registered nurses plus 26,000 nursing assistants, including more than 3,500 licensed practical nurses.

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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Complexities of Drug Therapy in Medical Practice

By RICHARD I. H. WANG, Ph.D., M.D.
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■ EVER SINCE THE late Senator Kefauver's investigation into the drug industry, a number of changes relating to the marketing of drugs has been made. The most significant change has been instituted by requiring new drugs to be effective as well as safe. This added restriction along with a reorganization of the FDA has resulted in a period of relative quiescence for the output of new drugs. Even though this period is temporary, it has provided us with a brief breathing spell to cope with the vast amount of information on drugs.

This is an opportune time for us to examine the status of our knowledge in drugs. This is the period for us to seek means of resolving our dilemma of drug therapy.

It is easier to state our aims than to fulfill them. Aside from our commonly experienced difficulty of keeping up with the current literature, there are many complexities of drug therapy. For the purpose of our own analysis it is imperative to illustrate some of the factors contributing to the complexities.

DRUG NOMENCLATURE

In the present educational curriculum the teaching of pharmacology to the second year medical students logically emphasizes nonproprietary names known frequently as the generic names. In the clinical years most drugs, however, are ordered by their proprietary names or trade names. The disparity of using different drug nomenclature is most evident for the second year medical students entering the third year of training.

Trade names are shorter, simpler, and easier to remember. Also, they are more frequently encountered. For example, Levoprome is the trade name for methotrimeprazine. The popularity in the use of trade names over generic names, however, is due to necessity and convenience rather than academic and scientific choice. An actual test of popularity was exemplified by a trial in this teaching hospital several years ago when a hospital policy was made requiring all drugs be prescribed under their generic names. This hospital policy lasted less than one day because of the physicians' difficulty in transposing trade names of drugs to their respective generic names.

EFFICACY OF DRUG THERAPY

Differing from the days approximately thirty years ago when effective therapeutic agents were few in number, knowledge of therapeutics is very important today. We have become more sophisticated and confident in diagnosing thyroid disease, congestive heart failure, hypertension, schizophrenic reaction, and so forth. We remain much concerned over our hesitancy in the use of a variety of drug therapies for different diseases.

To assess accurately the clinical value of drugs and to compare the pharmacological actions, dosages, and untoward effects of new drugs with the existing drugs of the same class is not simple. Such information requires the knowledge, effort, and wisdom of many devoted clinicians and investigators. Their unbiased and scientific conclusions can provide invaluable guidelines for others.

From Wood Veterans Administration Center and Marquette School of Medicine, Milwaukee, Wis. 53193.

COMPLICATIONS FROM SIDE EFFECTS

The potential complication which may result from treating patients with depressants or stimulants of the central nervous system is drug dependence. The hazards of unjustified use of narcotics, barbiturates, amphetamines, and tranquilizers have been described elsewhere.[1] It is pertinent to emphasize here that seemingly unrelated drugs such as antihistaminics and antihypertensives such as reserpine may produce the side effects of drowsiness and unsteadiness. These in turn lead to complication by altering mental acuity, judgment, coordination, and reflexes which are essential for safe driving.

ALLERGIC REACTIONS

Precise information on the incidence of allergic and other adverse drug reactions is not available. Both the AMA and the FDA are encouraging physicians to report the occurrence of such reactions. This reporting system hopefully alerts clinicians to the existence of a variety of adverse drug reactions.

Theoretically, very well known reactions should have been markedly reduced. In reality, some of the avoidable reactions are still quite common. An example of this complexity of drug therapy is the problem of cross-sensitivity in which patients with a history

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A NEW CO-EDITOR FOR "COMMENTS ON TREATMENT"

Richard I. H. Wang, Ph.D., M.D.

IT IS MY PLEASURE to introduce my associate Richard I. H. Wang, Ph.D., M.D., as the new co-editor for "Comments on Treatment." This feature has served an important role in past years in keeping the practicing physician aware of new advances and concepts pertaining to therapeutics. Originally this feature was co-authored by chairmen of pharmacology at Marquette and the University of Wisconsin medical schools. Times change and new developments have appeared on the medical scene which now permit us to offer our readers a new specialist, a clinical pharmacologist, who is better trained than I to provide you with special insight into the problems of therapeutics.

Doctor Wang is a clinical pharmacologist who has prepared himself for this specialty with extensive training in chemistry, pharmacology, and internal medicine. He holds the rank of associate professor in both pharmacology and medicine at Marquette School of Medicine. In addition, he is chief of the clinical pharmacology service at the V. A. Hospital, Wood, Wisconsin. Doctor Wang received his Ph.D. in pharmacology from the University of Illinois in 1952 and his M.D. from Northwestern University in 1955. Following a rotating internship at Presbyterian Hospital, Chicago, he served a medical residency at Indianapolis General Hospital where he first participated in clinical pharmacology programs. From 1958 to 1960 he served as a captain in the U. S. Army Medical Research Laboratory at Fort Knox, Kentucky. During this period he offered instruction in therapeutics in the department of medicine at the University of Louisville. After completing his military service he accepted an appointment as a principal research scientist at Roswell Park Memorial Institute and also maintained an appointment in medicine at the University of Buffalo. In 1963 he came to Milwaukee as an associate professor of pharmacology with the directive to develop a program in clinical pharmacology at Marquette School of Medicine.

Doctor Wang directs an active program in clinical pharmacology at the new V. A. Hospital, Wood, Wisconsin. To my knowledge it is the only V. A. Hospital which has a Clinical Pharmacology Service. In this role he provides consultation to his fellow physicians on therapeutic problems. He maintains active laboratory and clinical research programs in both basic and applied pharmacology.

I have known Richard Wang personally since 1949 when we were fellow graduate students in pharmacology. He chose to follow a new and uncharted pathway at that time in order to apply his specialized training in pharmacology to the problems of clinical medicine. Today his talent in the field of clinical pharmacology is in great demand by the major pharmaceutical companies. He will bring to you his extensive experience in therapeutic problems and unbiased evaluation of new therapeutic agents.

—Harold F. Hardman, Ph.D., M.D.
Professor and Chairman

of hypersensitivity to one penicillin are given another penicillin preparation or a semisynthetic penicillin preparation with a different trade name.

DRUG INTERACTIONS

The occurrence of drug interaction is frequently unexpected. Some of the interactions are due to chemical incompatibility. For example, the precipitation of sodium thiopental by the addition of an acidic salt of another drug such as meperidine hydrochloride in the intravenous fluid. Some of the interactions are on a pharmacological basis. For example, fatal reactions have been known to occur when sympathomimetic amines such as amphetamine, ephedrine, and certain cheese with high tyramine content were administered to depressed patients receiving monoamine oxidase inhibitors.

OVERDOSAGE

It is quite common, especially when we are not familiar with a particular drug, to administer it at suboptimal dose levels. To establish optimal therapeutic dose it is often necessary to produce a very brief moment of carefully supervised overdosage. Aside from the deliberate or accidental ingestion, self-administered overdosages of drugs are seen as a result of hypervitaminosis A and D. Relative overdosages of drugs are exemplified by the increased toxicity of digitalis in the presence of hypokalemia. Another example of the complexity of drug therapy is the occurrence of renal or auditory nerve toxicity due to overdosages of streptomycin, kanamycin, or polymyxin in patients with renal insufficiency.

DISEASES INDUCED BY DRUGS

It is not always correct to call drug-induced disease iatrogenic because self-administering of drugs is not uncommon. Most such diseases are rapidly reversible by taking appropriate measures and/or discontinuing the causative drug. In an attempt to control hallucination and delusion of our schizophrenic patients some of the phenothiazines such as fluphenazine and trifluoperazine may induce a Parkinsonian state with akathisia, tremor, rigidity, and even oculogyric crisis. These extrapyramidal symptoms can be easily controlled by the concomitant administration of an anti-Parkinsonian drug. Other examples of this type of complication are the proliferation of monilial infection due to the suppression of normal flora following the administration of antibiotics and sulfonamides and the exacerbation of acute gout following probenecid or chlorothiazide therapy.

The above remarks represent merely selected examples of the complexities of drug therapy in our medical practice. To solve some of our problems it is suggested that more of our time should be allotted to the reading of scientific reviews regarding modern treatment and drug therapy. It is further recommended that in medical conferences the choice of treatment, rational drug therapy, and pharmacology and toxicology of drugs should be discussed along with the usual presentation on pathology, radiology, physiology, laboratory findings, diagnosis, differential diagnosis, incidence, and prognosis of a disease entity.[2]

It is anticipated that coming issues of this section of the WISCONSIN MEDICAL JOURNAL will continue to provide useful information in the area of drug therapy. Hopefully, a collaborative effort in organizing a postgraduate program on the subject of modern treatment and rational drug therapy in this state will ensue.

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OUR APPRECIATION

Harold F. Hardman, Ph.D., M.D.

In the six years that Dr. Harold F. Hardman was co-editor of the "Comments on Treatment" pages, he distinguished himself as a dedicated author and editor with authoritative knowledge of the importance of basic pharmacologic principles in the problems of practical therapeutics. For two years he graciously accepted full editorship while a new co-editor was being sought. It is with much regret that the *Journal* accepted his resignation because of increasing administrative functions. His loyal support and efforts on behalf of these pages are deeply appreciated.—The EDITORS

SPECIAL TO THE JOURNAL

What the Extended Care Facility Expects from the Physician and the Nurse

By THE REV. C. A. BECKER, D.D., F.A.C.N.H.A.

Post President of the Americon
College of Nursing Home Administrators

Racine, Wisconsin

THE STATE MEDICAL SOCIETY of Wisconsin is to be congratulated for initiating the Wisconsin Work Week of Health. We of the American College of Nursing Home Administrators, Wisconsin Association of Nursing Homes, and the Wisconsin Council of Homes for the Aging are honored that along with some 20 other associations, we are listed as co-sponsors.

It is exactly what one would expect from such a highly knowledgeable and concerned society of physicians. It is, of course, also recognition of the fact that this is a day of a multiplicity of interlocking knowledge and services. Moreover, it is indicative of the fact that at long last we are employing a community and a human ecology approach to social–health problems. Patient care demands such a program.

As an aside, it should be stated that the relationship between the American Medical Association and the American Nursing Home Association and the American Association of Homes for the Aging has always been most pleasant. In fact, the first national accreditation program was the result of the combined efforts of the AMA and the ANHA. You have given us much needed counsel, guidance, and help.

This morning we had a bird's eye view of nursing homes and homes for the aged. In the last few years under the leadership of the State Department of Hospitals and Related Services and the several state associations, our facilities and program for the aging have been upgraded. There is, at long last, emerging a certain amount of professionalism in the field, at least among a minority group of administrators. True, we still have the inadequate home, the mediocre home, and the good, the accredited home. Hopefully, the day will soon come when we shall be proud—not merely of all of our facilities—but more important, our programs.

This afternoon our attention is focused on the Extended Care Facility. The *Conditions of Participation for Extended Care Facilities* are clearly defined. Medicare has not produced all the dire results predicted. True, there remain many unanswered questions and problems. In due time these will be solved. We should be eternally grateful that more adequate care has been given our aged. Much more is needed for our entire society.

Clear and precise is the role of the physician in the extended care facility. Thus, our presentation this afternoon is a restatement of what Medicare expects of the physician, as well as some of the experiences of the administrators. Not by any stretch of the imagination should it be assumed that my remarks are based upon personal experiences. Rather, they are a summary of experiences filtering in from across the State.

The extended care facility has been mostly a post-acute facility, whereas there is now an increasing emphasis on the sub-acute. For our purpose, we shall visualize the ECF as geared mostly to the aging, as is the case in Wisconsin.

Aging is only part of the total life span. It is necessary to focus on aging, isolated in a sense from the rest of development not only because it is useful in a scientific analysis, but also because of the special need of older people in our society. We firmly believe that just as a sick infant needs the care of the pediatrician, so does the deteriorating old man need the help of the geriatrician. It is a fine challenge to become an "expert" in the total life span, but it is a challenge greater, I assume, than many physicians can, or wish to, meet.

Thus, I am voicing the hope that we could train more geriatricians in the field and that the profession be re-enforced with the relevant behavioral, physiological and sociological sciences. We need to learn to know the aging far better if we are truly to understand and help. We need to research the complex processes of transformation affecting adults through the second half of their life span. We need to examine the myriad complexities of change—the biological influences, the social and cultural determinants, the special senses and perception, every facet of the aging process and its inherent systems of change, speed and timing in development and aging, psychomotor skills, learning, thinking and intelligence, employment and productivity, personality and aging, maladjustment and psychopathology—all.

It wasn't too long ago that we thought old people needed nothing but respect and tender loving care—it mattered little who gave it or how professional the approach. Hopefully that day is past. Today we realize that the emphasis must be on restorative nursing; that physicians trained in geriatrics are needed; that coupled with these must go the behavioral sciences.

Presented at the Fifth Annual Wisconsin Work Week of Health, State Medical Society of Wisconsin, Oct. 16–20, 1967, Madison.

So quite frankly we voice the hope that with the advent of the specialized extended care facility, more medical schools recognize aging as a specialized field; that medical research catch up with behavioral science research; that more discussions in the local county medical society be focused on the geriatric and that specialized treatment be practiced.

The *Conditions of Participation* suggest that our ECF have a medical director. For years, many of us have urged this. Alas, the average administrator was either too frightened or too proud to invite the help of the physician and the physician all too often looked at our facilities as a necessary evil. Yet today we all realize the necessity of a medical director. Obviously, the position should not be one in name only, an occurrence which too often is the case. Nor should a medical director merely be a resource in case of an emergency. It is to be hoped that you will truly upgrade the administration of our facilities and assist in the implementation of a program that meets the needs of the "whole" person.

So we emphasize that the physician must take his role seriously. It is essential that the county medical society recognizes the role of the ECF, its purposes, goals and hopes. This cannot be achieved unless the individual physician understands the role and function of the ECF in detail. The interpretative role of the medical director is, therefore, essential. It would seem appropriate to invite the administrator of the ECF to one of your meetings for a presentation. Better yet, for the administrator to invite the society to his facility for a tour and discussion. Only in this manner can true empathy be established and cooperation result.

It seems almost essential that a medical staff be developed, a staff with rules and regulations for the ECF in the community. This does not necessitate another meeting for the already overburdened physician. It can become part of his regularly scheduled meeting. This can be done in various ways.

But there are some specifics we should also discuss. They are:

1. The *Conditions of Participation* stipulate that a transfer of a patient must be accompanied by medical and other necessary and useful information. This includes current medical findings, diagnosis, rehabilitation potential and course of treatment. Yet how often do we receive patients with such detailed information? Patients are transferred with a minimum of medical information. Then after the arrival of a patient, following the report of the social worker, the sociological report and the nurse's records, we find we have a patient quite unlike that indicated on the original report. This affects not only the initial care of the patient but also the placement of our patients, and often causes severe traumatic experiences for our other patients.

2. Medicare stipulates that benefits may be extended up to 100 days. It does not state that a patient automatically receives 100 days. Yet how many patients invariably greet us with, "My doctor told me I will get 100 free days at your home." Well, in the first instance, nothing is free and by no stretch of the imagination is a 100-day benefit automatically granted. The Utilization Review Committee determines the length of stay. We do not exist to give free rides on your and my tax dollar. We urge some of you to be more discrete in discussion of Medicare benefits.

It may come as a shock to you to learn that not a few patients certified by physicians as a Medicare patient, are not accepted as Medicare patients by the Fiscal Intermediaries. It is well to remember that eligibility as a Medicare patient is carefully prescribed.

Just recently a six-page letter clearly defined conditions. Great care must be taken to distinguish between "custodial care" and "skilled care" patients. Patients needing merely custodial care are disqualified. Patients who can receive medical attention outside of a skilled care facility are not eligible. Most people who lack rehabilitation potential are excluded. There are of course exceptions, such as the cancer patient.

"Skilled service" is defined as that which must be furnished by or under the supervision of trained medical or paramedical personnel if the safety of the patient is to be assured and the medically desired result is to be achieved.

3. The *Conditions of Participation* stipulate that oral orders for medications are to be signed or countersigned by the physician within 48 hours. This is the rule. We cannot, therefore, assume that this is physically impossible for the physician. This is his responsibility. But because this works a hardship on some physicians, the practice is to send a copy of the order to the physician's office with the request for a signature. It is then returned and stapled to the original. But even this courtesy doesn't elicit cooperation from some physicians. There are even those who bitterly complain because the stamp is omitted for the enclosed self-addressed envelope. Even though a five-cent stamp will not work a hardship on either the physician or the ECF, whose responsibility is it? He is the physician's patient. The physician is to sign the order. What shall we do with the physician who does not respond, or acts as if he is doing us a great favor?

4. The *Conditions of Participation* stipulate that the physician is to call on his patient at least every 30 days. The patient chose his physician and the physician accepted him as his patient. Therefore, it clearly is the physician's duty to visit him at least every 30 days. Again, because this coverage is lacking, we follow the practice of notifying the physician in advance either by mail or telephone of the termination of the 30-day period, hoping against hope that the physician will come for his visit. Yet so often that visit is not made.

Yes, we all realize the shortage of physicians. We know that physicians have little rest at night. But we reiterate, physicians have patients. Legally and morally, physicians have a responsibility to call

on their patients every 30 days. Shall we lose our certification because of the physician's failure to visit?

5. The *Conditions of Participation* stipulate that we should use restorative nursing. This includes the use of the registered occupational therapist, physical therapist, speech therapist, dietitian, and the like. These are formally trained individuals with a considerable body of knowledge. They are to assist the physician in evaluating the patient's level of function by applying diagnostic and prognostic tests—guide the patient in his use of therapeutic creative and self-care activities for improving functions.

We know full well that most physicians are well-acquainted with these services and their benefits. Quite naturally, we are shocked when physicians fail to use these services or when they blithely remark, "Oh, he is such an old person, why should he have to work for a living?"

I have witnessed, and physicians too, many wonderful recoveries through properly charted modalities of services. We want to use our high salaried staff members. We cannot use them unless their services are prescribed by the physician. We ask physicians, when charting patient's program, to remember that we have these staff members and that the physician consider their use in rehabilitation plans.

Hopefully, physicians have not misunderstood my presentation. We do appreciate the sincere concern of the physicians. By and large, the vast majority of physicians has gone the second mile in assisting us with our facilities, problems and weaknesses, and with the Medicare program. We deeply appreciate the magnitude of the physician's help.

As in our profession, it is those who do not understand the program who pose the problem. They create a problem, problems which can result in the loss of our certification as an ECF. Losing that, we deny our people the benefits of Medicare and we lose our self-respect.

Hopefully, in discussions such as this, we can learn to understand each other better. Together we should work for a socially healthy community.

TESTING UNIT AVAILABLE FROM WHA

"Work Prescription for Heart Patients," a testing unit prepared by the Committee on Medical Education of the American Heart Association is available from the Wisconsin Heart Association.

The test, in booklet form, allows physicians to test their diagnostic ability. After reading three case histories and studying the pertinent x-rays and electrocardiogram tracings illustrated in the booklet, the physician answers multiple choice questions about each case and then checks his own answers.

The "Work Prescription for Heart Patients" test is available at no cost by writing: Wisconsin Heart Association, 205 W. Highland Avenue, Milwaukee 53203.

PAMPHLET FOR MOTORCYCLIST

Head injuries are the most frequent cause of death in a motorcycle accident. Most serious nonfatal injuries, however, involve the legs and lower arms.

These facts are brought out in a new pamphlet on the proper attire and equipment for the motorcyclist who wants to avoid injuries to himself in an accident.

The pamphlet is called "Your Motorcycling Fun and Personal Protection" and is published by the Injury Control Program of the Public Health Service's National Center for Urban and Industrial Health in Cincinnati, Ohio.

Jerome H. Svore, Director of the Center, said that for good protection a motorcyclist should have an approved safety helmet, goggles or face shield, rear view mirror, durable trousers, sturdy boots or shoes, leather gloves, leather jacket, and windshield.

Single copies of (PHS Publication No. 1632) is available from Public Inquiry, National Center for Urban and Industrial Health, 222 East Central Parkway, Cincinnati, Ohio 45202. It may be purchased in quantity from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402 at 5 cents a copy.

CLINICAL CENTER STUDY OF MALIGNANT LYMPHOMA

The cooperation of physicians is requested in a study of lymphosarcoma and reticulum cell sarcoma in children and young adults. This study is being conducted by the Medicine Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Slides of pathologic material must be submitted for review before patients can be accepted.

Of particular interest are those patients with clinical and histologic features similar to the malignant lymphoma of African children (Burkitt tumor). These patients generally present with jaw, ovarian, or abdominal masses. The purpose of this study is to conduct immunologic, virologic, pathologic, and chemotherapeutic studies.

Suitable patients will be admitted to the Clinical Center in Bethesda, Maryland, or to one of the participating medical centers. Physicians who wish to have their patients considered for the study may write or telephone: Paul P. Carbone, M.D., The Clinical Center, National Institutes of Health, Building 10-Room 12-N-226, Bethesda, Md. 20014; telephone: 656–400, ext. 64251 (Area code 301).

THE PRESIDENT'S PAGE

HAROLD J. KIEF, M.D.

SMS means aggressive leadership

The Blue Plans—A Plea

"He that will not apply new remedies must expect new evils."
—BACON

■ IN 1966 ALL PHYSICIANS were obviously very depressed by the advent of Medicare and Medicaid, and wondering if anything should or could be done about it. Then slowly a picture evolved. There was a picture of consumers demanding economic stability by being assured that all of their health care needs would be met. And then there was the other side of the picture, I think, of the medical profession saying, "We are delivering health needs. Oh, there may be some areas where there are deficiencies but we are doing a good job with what we have." And I think, doctors, looking in a mirror will tell us that maybe we, in the profession, are not quite as right as we believed.

The medical profession then began taking another look. An era thus began in which better cooperation with all other sectors concerned with health care became most important. Slowly we began to realize that the whole issue of quality in medical care is inseparable from the economic environment in which we practice, and that we can influence this environment to a considerable extent.

Thus, the Blue Plans were challenged; challenged by the profession, by industry, by labor, and by the public. The Blue Plans have been urged to look at the entire spectrum of medical care and make it available and flexible enough to meet the changing needs of the community. I believe that the Blue Plans should expand their research in developmental activity to exert leadership rather than respond entirely to the customer-designed benefit demand.

The consumer, largely through collective bargaining, is articulate and has power. Because of this, his demands are more numerous and more sophisticated. The challenge of the Blue Plans is to respond and to supply this demand *judiciously!* The Blue Plans have assumed the role of intermediary between government and the provider in many areas (Medicaid and Medicare) and also under the voluntary prepaid sector. In this the Blue Plans have accepted a rather serious obligation of demonstrating that the private provider and the private financial mechanism can in fact deliver a product of good quality and at reasonable prices.

A portion of this philosophy we as physicians know and accept, but what I think many of the physicians do not fully realize is that the Blue Plans, as a private insurance sector, must continually move, explore, and *lead.* Yes, lead to mechanisms of payment for the *full health* care of the patient with prepaid insurance for *all members* of the health team. This type of program we could not envision some months ago, but I think that it is very simple, really: this intelligent public, that we as physicians serve, point blankly states, "A government insurance program has been devised to give me full coverage for grandma, and why can't I have it just because I am 32?" This type of philosophy may seem foreign to some of the leaders of our profession. However, we must realize that the concepts of our thinking must change continuously and grow. For if the providers of medical services in this state and the Blue Plans, the voluntary insurance

plan of our state, are to work together delivering all of the medical care to the consumer, our people, it is very obvious that we must work in close harmony and that our philosophy must be the same. I do not know who should lead really or that there should really be a leader, but the philosophies of medicine and the philosophies of the Blue Plans must coincide. Above all government must be shown that it is less expensive the voluntary way and that it's workable in a continued evolutionary progression of ideas and methods.

G. K. Chesterton once said, "I do not believe in a fate that falls on men however they act; but I do believe in a fate that falls on them unless they act." Therefore I make a plea, that the Blue Plans act now in the development of new programs, that the Blue Plans and the physician continue to work together in *informed, intelligent harmony* so that we, the providers of medical care, can deliver this service to all of the people more efficiently and economically.

R. J. Kieff MD

CONTINUING EDUCATION PROGRAM

UNIVERSITY OF WISCONSIN

The following continuing education programs are provided by the University of Wisconsin, through University Extension and the Medical Center. Those marked (*) are presented in cooperation with the Wisconsin Regional Medical Program, Inc.

On-Campus Courses

Three courses are scheduled this Spring. Additional courses will be announced as dates are set.

Feb. 7– 8 A Symposium on Modern Separation Methods of Macromolecules and Particles

Mar. 27–28 Third Annual Postgraduate Teaching Day in Sports Medicine

Apr. 4– 6 A Symposium on Fetal Medicine

Telephone/Radio Conferences

This year 68 hospitals are taking part in conferences for physicians and allied health personnel. Hospital enrollment for the next academic year will begin this Spring, with programming planned for the following personnel:

Physicians
- General Medical Seminars
- 4–6 Specialized Medical Courses

Allied Health Personnel
- Hospital Administrators
- Medical Technologists
- Radiological Technologists
- Nurse Anesthetists
- Medical Librarians

Telephone Dial Access Library*

Announcement of 175 recordings available by telephone is being made in January. Additional recordings will be announced on hospital bulletin boards as they become available.

Single-Concept Films*

A series of six films of 6–10 minutes duration, shown on an automatic projector in your hospital, is currently available. Fifteen additional films will be produced this year under the auspices of the Wisconsin Regional Medical Program, Inc.

Physician-In-Residence

One to two-week courses of individual study are available to physicians who wish to return to an academic setting for study in depth in a specific area. A course is presently available in Pediatrics and others will be arranged on individual request.

For further information on any of the programs, write: Thomas C. Meyer, M.D., Associate Dean for Postgraduate Education, Room 302, 333 North Randall Ave., Madison 53706. For courses associated with the Wisconsin Regional Medical Program, write: Roy T. Ragatz, Room 305, 333 North Randall Ave.. Madison 53706.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

FEBRUARY 1968
Vol. 67 No. 2

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Medical Public Utility

■ THE *MILWAUKEE JOURNAL* recently editorialized regarding the proposal of Dr. Kerr L. White of Johns Hopkins University School of Hygiene and Public Health calling for a reorganization of medical practice under federal aegis so that the entire country would be "efficiently" covered. Doctor White used the airline industry as a model and suggested that medical practice be publicly franchised, like any other type of public utility, and publicly regulated, supposedly to guarantee minimum standards of performance.

In a classic understatement, the *Journal* opined "The White recommendations are unlikely to be embraced warmly by his fellow physicians." The newspaper thought that the proposals merited consideration "as a way to provide better health care within the framework of private medicine."

It is difficult to understand why medical thinkers and newspapers as sophisticated as the *Milwaukee Journal* both persist in beating the medical profession over the head with this old chestnut of a disjunctive proposition that simply isn't true. On the one hand is the specter of a "monolithic national health services system," and on the other is the alleged "present disorganized arrangements for providing fragmented medical care." Is there not an obvious middle ground between the two alternatives? Are the White proposals anything other than the "monolithic national health services system" the *Journal* seeks to avoid?

Any scheme such as Doctor White's proposals is doomed to failure for at least two very valid reasons. The extension of adequate health care to the large disadvantaged section of the nation is a political and economic problem, and not only a medical problem. When the economic levels of the impoverished are elevated and when health care facilities are provided under the present mechanisms, adequate medical treatment is a concomitant. Areas in which adequate health care is lacking are always characterized by abysmal poverty and long-standing political and social oppression. If the philosophy of the War on Poverty could be successfully implemented—and the federal government is betting big money that it can be—there would be no need for a "monolithic health services system."

Secondly, and perhaps more importantly, the practice of medicine is a very personal matter. Some doctors prefer to pursue their profession in universities and colleges. Others find group practice congenial; a great many doctors, for a variety of reasons, prefer to practice alone as individuals. Under Doctor White's plan, each doctor would be assigned to a "crew" stationed in a specified locality, subsidized by public money and regulated by public rules. While some group practices such as Doctor White envisions now exist and work well, it is a certainty that not all doctors will fit into the regimen of group practice. The solo-type doctor is a rugged individualist, and to force him into group practice is courting disaster.

Medical practice is not a public utility, nor is it a business such as the airlines, and any comparison is fallacious. Doctor White and the *Journal* overlook the intensely personal nature of medical practice, both for the doctor in terms of his own personality and for the patient in terms of the close interpersonal relationship he must establish with his physician.

To eliminate the action of natural selection in a doctor's choice of his life's work can only destroy the doctor's efficiency as well as the enterprising aspects of his role as a healer. From a practical point of view, what Doctor White proposes and the *Milwaukee Journal* endorses might be the mindless pill peddling of an army dispensary.

—DNG

Accurate Recognition

A FEW MONTHS AGO, we applauded the program of a pharmaceutical manufacturer to code an identification symbol on the pills and capsules it produced. We pointed out the many benefits both to the patient and to the doctor that resulted from the new system.

It is gratifying to note that Parke, Davis and Company is following suit with a simple system of its own. The initials "P–D" and a three-digit number are embossed or stamped on all coated or compressed tablets and capsules the firm produces. A listing of the numbers in numerical order is being distributed to every drugstore, doctor's office, hospital, and nursing home in the country.

Hopefully, other pharmaceutical manufacturers will adopt a similar system, and eventually, a universal system of pharmaceutical identification will prevail.

—DNG

* * *

THE DENTIST AND CANCER—A new American Cancer Society film for dentists and dental students. Running 21 minutes, the film demonstrates in detail an oral cancer examination, includes shots of a variety of early lesions, indicates importance of good prosthetic dental care in rehabilitating patients. To arrange a screening, call your local ACS office.

* * *

THE DIAGNOSIS AND MANAGEMENT OF CANCER OF THE COLON-RECTUM—A new 17 minute film for physicians and medical students released by the American Cancer Society, stresses the importance of routine procto exams and demonstrates detection and treatment of both symptomatic and asymptomatic cancer of the colon and rectum. Showings may be arranged through your local ACS.

EDITOR'S NOTE

The conference on quackery at the Milwaukee Auditorium last November, produced by the Commission on Health Information of the State Medical Society of Wisconsin, was a superb program and one can only regret that every resident of Wisconsin couldn't be there. One of the many outstanding papers was delivered by Mr. Ray O. Jondahl, President of the Wisconsin State Chamber of Commerce, who pledged the active support of his organization in the fight against the vicious menace depleting the health and financial substance of thousands of people. The perceptive article, reproduced on the opposite page, written by Mr. Ken W. Haagensen, Executive Vice President of the Wisconsin State Chamber of Commerce, appeared in the December 1967 issue of *Wisconsin Business News*. The Chamber deserves the sincere thanks of the medical profession for its interest and positive approach. All of us should be inspired to increased effort in the struggle against charlatanry.

—DNG

Prepared by
Wisconsin State Chamber of Commerce
411 West Main Street, Madison, Wis. 53701

CHAMBER BRIEFS

A REVIEW OF DEVELOPMENTS OF INTERESTS OF THE WISCONSIN BUSINESS COMMUNITY

by KEN W. HAAGENSEN
Executive Vice President
Wisconsin State Chamber of Commerce

Recently the State Chamber participated in a conference on the high cost of quackery.

The two-day meeting in Milwaukee was sponsored by the State Medical Society of Wisconsin.

It was most revealing. According to authorities, upwards of $2 billion is spent annually by Americans for health nostrums that are useless, sometimes dangerous and always expensive. That $2 billion is more than all the money spent for legitimate research on disease in any given year.

We have our quacks in the Business World, too; we just call them by another name, "fast-buck artists," for instance

During the conference the question arose: "How do you deal with these charlatans?" One method is through enforcement agencies such as the Federal Drug Administration in the health field and the Securities Exchange Commission in the business field. We need proper law enforcement groups.

But there is a danger. In the zeal to protect the public, you can over-regulate, over-organize, oversee and over-investigate and over-control to such a point that you stifle Initiative, Imagination and Enterprise. In short, you can kill a free society with massive doses of protectionism.

We of the Wisconsin State Chamber of Commerce — make no mistake about it — want to see quacks in medicine and in business stamped out. We want them to become as rare as the Black Plague. But we want to be sure of the methods used to inoculate our citizens against them.

In our State Capitol in Madison and in the Nation's Capitol in Washington, D. C., our Chamber very carefully examines the kinds of legislation that is proposed to regulate business. Some of it is excellent — and some of it is pretty bad. Some of it is needed, necessary, vital for the economy. And some of it reminds one of that oft-told doctor's story: "The operation was a complete success — but the patient died." In this case, it would be Free Enterprise on the deathbed.

To sum it up, our State Chamber is pretty chary about legislation that restricts one kind of business at the expense of the rest of the business world.

What we much prefer is what the State Medical Society did in the Milwaukee Auditorium for two days: turn a searing, hot searchlight on the frauds and gyp artists in the field of health. Where there isn't a clear and present danger, such as there might be in a fake drug, let the public beware through the thorough process of education.

An educated public is much better than a strictly regulated public. Indeed, a regulated, but ignorant, public might well take to the back alleys and black markets to obtain health nostrums if they were entirely ruled off the sales counter.

In preparing for the quackery conference, the State Chamber developed some statistics on what it costs Wisconsin generally to buy gadgets, gimmicks, potions and poultices in the hope of health.

We estimate that some $40 million dollars are handed over to quacks every year by the people of Wisconsin. That is a staggering sum of money. It is about three times more than the United Givers Fund received this fall from the whole of Wisconsin. That kind of money would pave a four-lane superhighway all the way from the center of Milwaukee to the Illinois border.

How much does quackery cost Wisconsin business, we were asked. There isn't a good way to measure it. When a worker is sick, he may or may not see a licensed physician. He may or may not buy some remedy and doctor himself. He may just lie in bed at home and hope for the best.

Even if we can't estimate the price, you can be certain there are hidden costs to a business firm when the quack takes over. When a man on the job grows ill and follows the quack's advice, his ailment lingers on. It means extra days in bed, away from the job. There is sick pay, a hidden cost. And when a man is sick, there is a weakening of the will to work. There is a weakening of the ability to work. There is a weakening of the energy to work. And there is mental turmoil because the illness does not respond to treatment. All these are hidden costs — to the man himself and to his employer.

There are other hidden costs that we can lay at the quack's door. Undoubtedly a good portion of the quack's dollar comes from the poor in income, the poorly educated, the poor of health, and the elderly, who, by the way, make up better than ten percent of Wisconsin's population.

Inflation has hit these people particularly hard. It is quite conceivable that there are thousands of these very same poor and elderly people in Wisconsin, living on fixed or small incomes, who have had to cut back on their daily diets to find money for the insidious practitioner of quackery.

And with inflation on the increase, it will mean more cutbacks in their healthy foods for more money for more health fads. Talk about a vicious circle! This, mind you, in a state that is world famous for nutritious foods: our dairy industry, our vegetable industry, our meat industry, our fruit industry.

But how are we going to get this message across? We proposed to the State Medical Society a nine-point educational program that could be of major assistance.

Combining together with all our resources, we could turn that $40 million dollar wasteland of mythical cures into one of the great contributions to "the good life" in this Wisconsin of ours.

(Reprinted with permission from WISCONSIN BUSINESS NEWS, December 1967 issue.)

LETTERS

OFFICIAL PHYSIATRIST GROUP

To SMS:

The Wisconsin Division of the Mid America Society of Physical Medicine and Rehabilitation is the only and official organization of Physiatrists in the State of Wisconsin. As such it is most anxious to be of service not only to its membership, but also to the rest of organized medicine, particularly on local and state levels.

We would be most appreciative of being informed of any problems directly or indirectly involving our area of medicine that we might furnish help and advice in their solution. Our membership, although small in numbers unanimously is willing to serve on committees relative to our field or to act as liaison representatives to other groups.

Particularly, we would like to be notified of inquiries from out-of-state physiatrists relative to positions within our state, and from state hospitals and institutions seeking physiatry services. We feel that, with the cooperation of our affiliate societies in nearby states, we can be of great assistance in these matters.

PAUL A. DUDENHOEFER, MD
Chairman, Wisconsin Division

VIETNAM VOLUNTEER PRAISED

To the Secretary, AMERICAN MEDICAL ASSOCIATION:

Devotion to duty, while expected of a member of the military services, is especially laudatory when the individual belongs to the civilian community and exhibits such characteristics. Such an individual is Dr. Victor S. Falk, 5 West Rollin Street, Edgerton, Wisconsin 53534.

To volunteer two months of one's time without remuneration to help relieve the suffering caused by the acts of war and to help improve the general health of Vinh Binh Province through his skill as a surgeon and teacher, Doctor Falk exemplifies the highest characteristics of an American. He willingly donated his time and efforts for two consecutive tours and, even while in private practice, he has worked unceasingly to achieve support for our efforts through funds and much needed supplies. Doctor Falk has collected, through his talks to the American people, over $400.00 for the Phu Vinh Catholic Orphanage and over $1500.00 for medical equipment and supplies for the Province Hospital. Finally, while he was here, Doctor Falk made innumerable friends among the Vietnamese and was definitely a valuable asset to the American effort in Vinh Binh Province.

RALPH W. GIRDNER
LTC INF
Province Senior Advisor
Headquarters
US Military Assistance Command, Vietnam
Advisory Team 57 (Cords)

SUICIDE PREVENTION

To DOCTOR GOLDSTEIN:

I want to thank you for your fine editorial, "The Total Drop-Out," in the November issue (1967) of the Journal. The issues you raise are important extensions of my paper. Buying time to mobilize others in the community, such as clergymen, is a responsible way to combat feelings of hopelessness and isolation. Moreover, you place the role of the physician in appropriate perspective.

I am sure your editorial will have an influence upon the medical community.

CARL I. WOLD, Ph.D.
Los Angeles, Calif.

WANT TO TOUR AMA HEADQUARTERS?

Planning to be in Chicago in the foreseeable future? Then why not take time out from your vacation or professional schedule to visit AMA headquarters.

Physicians, their wives and guests are welcome to visit the building, located at 535 North Dearborn just north of the Loop, anytime during office hours —8:30 to 4:45 Monday through Friday—for a 45-minute guided tour of the nine-floor building and its offices.

Tours are conducted by specially trained headquarters employees, who seek to acquaint visitors with the organizational structure of the AMA, major areas of activity and many of the services available to physicians and the public.

To arrange a tour in advance, just write Miss Patti Chapman, director of the AMA's Tour Guide program, at the Program Services Department. If advance notice is not possible, just report at the reception desk that you desire to have a tour of the building.

During the third quarter of 1967 nearly 500 persons were conducted on tours of the headquarters offices. This unusually heavy schedule, almost equaling tour attendance for the entire preceding year, indicates increasing personal interest in the AMA by individual physicians. Approximately 60 per cent of those taking tours are physicians. The remainder are medical society personnel, members of the Woman's Auxiliary, medical assistants, those employed in allied health professions and students.

SECTION OPHTHALMOLOGY

FEBRUARY 1968 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

INTRODUCTION

With this issue of the WISCONSIN MEDICAL JOURNAL, readers will be introduced to this special monthly page, sponsored by the Section on Ophthalmology of the State Medical Society, and edited by Dr. James C. Allen of Madison.

Its purpose is simple: To improve the avenue of communication among ophthalmologists, and between ophthalmologists and some four thousand other physicians in our State Medical Society, making them more aware of ophthalmology as a science and appreciative of the problems peculiar to ophthalmology.

Its scope will be variable, reporting items of interest on scientific, educational, socioeconomic, and legislative ophthalmological activities as they apply to physicians throughout the state.

Readers are encouraged to send comments and suggestions to the editor (Section on Ophthalmology, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wis. 53701) as to the substance and format of this page, for it is our hope to provide the physicians with useful information.

SECTION OFFICERS

Chairman: James V. Bolger, Jr., MD, Waukesha
Secretary: William H. Bennett, MD, Racine
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MEDICARE–SOCIAL SECURITY AMENDMENTS OF 1967

The 1967 Amendments to Public Law 89–92, Title XVIII (Medicare) excluded from coverage certain services of physicians that particularly affect patients of ophthalmologists. Heretofore, payment for "examinations for the purpose of prescribing, fitting, or changing eyeglasses" has been excluded. Now, Congress has in addition excluded "procedures to determine the refractive state of the eye," whether performed as an isolated service, or performed in the course of a comprehensive diagnostic medical eye examination. This was done in spite of medicine's position that physicians do not examine for the purpose of prescribing eyeglasses but is incidental to, and part of, the complete medical eye examination, and is neither rendered, nor charged for, as a unit of service. But Congress, under heavy pressure to provide services of nonmedical practitioners, felt that such physician services should not be paid, because refractive services by optometrists are not paid for.

A problem arises when the Medicare "carrier" (in the state of Wisconsin: Wisconsin Physicians Service [WPS]) must determine from a bill rendered by a physician performing certain services, whether it contains "procedures to determine the refractive state of the eye" and what its value is relative to the submitted bill.

It is the suggestion of the American Association of Ophthalmology's Committee on Medical Service and Prepayment Plans, whose chairman is Dr. Charles E. Jaeckle, for the appropriate medical groups in each state to work with the carrier to establish definitive procedures customarily performed in the physician's office, and adapt descriptive terminology with respect to the procedures or services, and to develop a billing code number (similar to that used in surgical procedures), and to attach values to these services, with a certain percentage being "carved out" when it includes a "refractive procedure."

In order to implement this suggestion, the State Medical Society's Section on Ophthalmology has appointed and activated a committee to work with Wisconsin Physicians Service.

If further information is desired on this subject, write the editor (address noted above), for a reprint of Doctor Jaeckle's Committee on Medical Services and Prepayment Plans Report to the AAO.

The Executive Committee of the Section met late in January with representatives of the State Medical Society and the WPS Division, which is the carrier for Part B Medicare, and adopted a recommended billing procedure and coding to facilitate administration of ophthalmologic benefits under the new amendments. This information will be sent to all physicians.

LEARN TECHNIQUE OF TONOMETRY

Dr. George Sparks, consultant in ophthalmology to the Wisconsin Division of Health, will be available until July 1 to visit and personally teach the technique of tonometry to any Wisconsin physician who would like to learn to test for glaucoma suspects as part of a complete physical examination on anyone over age 35. A nurse or technician with average dexterity also can perform tonometry with proper instruction. Contact: George Sparks, MD, Box 309, Wisconsin Division of Health, Madison, Wis. 53701.

If any physician is interested in developing a glaucoma program in his community contact, the Wisconsin Society for the Prevention of Blindness, 312 East Wisconsin Ave., Milwaukee, Wis. 53202; or the Section on Ophthalmology, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

THE MEDICAL STUDENT FORUM

Devoted to the expressions of the medical students at the University of Wisconsin and Marquette medical schools through association with the Student American Medical Association. A feature originated by the State Medical Society of Wisconsin to stimulate closer relationships with the physicians of tomorrow. This space is offered monthly to both schools on an alternating basis with copy deadline the first of the month preceding the month of publication. Statements and opinions contained herein are those of the students.

IT IS APPROPRIATE that in the initial contribution to this unique and unprecedented feature there be a discussion of what SAMA is, how the various chapters function, and something regarding those persons who comprise the membership.

In December 1950, SAMA was founded in response to the needs of students in various medical schools to have a representative and responsible means of expression at a national level. The idea was well accepted, and today SAMA has chapters in 80 medical schools in the United States with an additional chapter in Puerto Rico.

WHAT IS SAMA?

The organization publishes a monthly journal, *The New Physician*, convenes national meetings to discuss and vote on issues pertinent to the medical student and elects national officers, and forwards recommendations and opinions to the appropriate organizations and bodies. In addition, programs which are beneficial to medical students as a group are developed and supported. These include scholarships, loans, insurance programs, competitions, exhibits, and extensive liaison programs with other organizations.

MARQUETTE PROGRAM

At the local level the functions of SAMA vary from school to school. At Marquette each class elects its own officers so that SAMA has a minimal political function and generally operates independently of, but in close cooperation with, the medical school. Two medical fraternities, Alpha Kappa Kappa and Phi Chi, furnish an adequate social environment, making Marquette's chapter of SAMA primarily a service organization.

Traditional functions at Marquette include a school newspaper, a career day to acquaint high school and college students with medical and paramedical fields, a freshman-faculty banquet, a big brother program in which each freshman is assigned a sophomore to assist him in beginning his medical education as gracefully as possible, and the SAMA Ball.

An attempt is presently being made to expand the functions of SAMA at Marquette by exposing the medical students to aspects of an overall education which he might not otherwise encounter.

Last year a speaker program was introduced. To initiate the series Dr. Sidney Cohen of the University of California at Los Angeles spoke on hallucinogenic drugs. This year some of Marquette's SAMA members have become interested in community health programs, a trend which is sweeping the country. An internal affairs committee is presently being established to determine the feasibility of a high school visitation program which would have as its goal the stimulation of interest in medicine or a paramedical field at a time when the impressionable high school student might seriously contemplate medicine and related professions. Also, recognizing the paucity of sex education in medicine today, a series of programs is being explored to acquaint medical students with sex education as it applies to medicine.

ROLE OF MEDICAL SOCIETY

An often overlooked aspect of SAMA is the opportunity presented the medical student who is interested in developing an appreciation of the role medical societies and student medical societies have in medicine today. While most students are interested in the society journal, insurance programs, and the passive benefits, less than 20% actually participate with time and energy. The officers represent only 1% of the student population. This 1% carries local attitude and opinion to the national meetings. Justifiable criticism is offered that this group is not a random sample. Nevertheless complicated and perplexing matters are studied extensively at the annual convention and acted upon by this group. Since ours is a student organization, our opinions are heard and respected. However, in all truth, very few issues have been influenced by our recommendations. Two notable exceptions are the internship matching program participated in nationally by 97% of graduating seniors and the AMA-ERF loan program.

SAMA is viewed by many as a progressive student counterpart to the conservative official policy-making body of the American Medical Association. Yet many medical students consider SAMA to be less than dynamic and aggressive. Because of this attitude another group has recently been formed, called the Student Health Organization (SHO), which arose out of a mutual interest, by many medical students, in community health. Since its origin approximately three years ago, SHO has diversified and now issues statements on many matters affecting students in the health professions. Today, therefore, there are two organizations expressing student opinion—SHO reflecting primarily attitudes of schools in Chicago, New York City, and California, and SAMA accounting for most of the remainder.

DIFFERENT STUDENT TODAY

It is important for practicing physicians to realize that today's medical student differs in many respects from his counterpart of 20 years ago. In pyramiding his knowledge he has more information from which to draw. He is married, more often than not, with a family when he graduates. His debts are considerable. He is the product of a changing culture which can accept Medicare with minimal reluctance. These factors and others will mold the concepts and attitudes which today's student will carry into medicine, as well as those which will guide him as he attempts to modify medicine in the forthcoming years. Conflicts are bound to arise, but these will benefit the profession.

THANKS

Hopefully today's medical student will arouse physician curiosity and stimulate more interest. After all, it is to the physician, as advisor and teacher, that the medical student looks for his guidance and training.—BRUCE D. BUCHANAN, President, SAMA, Marquette.

the wisconsin medical journal

VOLUME 67/NUMBER 3 MARCH 1968

Emergency Room Principles in Limb Amputation and Replantation

By MICHAEL A. POLACEK, M.D., F.A.C.S., THOMAS PAGEDAS, M.D. and EDWIN WELSH, M.D., Milwaukee, Wisconsin

■ WITH THE EXPANSION of our mechanized society, the incidence of trauma to the extremities has shown an alarming statistical increase. This is true not only because of industrial development but also as a result of rising domestic accidents, especially with the increasing popularity of home power tools such as lawn mowers, work shop equipment, and snow blowers. More than 100,000 persons are injured annually in this country by power lawn mowers, of which there are now over 25 million. Most of these injuries are finger or toe lacerations, but there are also numerous amputations and there have been over 100 deaths.

The rotary type mower is the most commonly used around the home. Blades of such rotary mowers rotate up to 4,000 times a minute and can hurl loose objects buried in the grass with a force of more than 10,000 pounds per square inch at speeds equal to that of shell fragments. Nearly 70% of all lawn mower injuries occur through direct contact with the blade, but not infrequently an injury results from small objects being pulled up from the grass and thrown outwardly by the whirling blades of the mower. Although the injured person is usually the operator, all too often it may be an innocent bystander in the vicinity.

From the Departments of Surgery and Physical Medicine, St. Luke's Hospital.
Reprint requests to: Michael A. Polacek, M.D., 2900 West Oklahoma Ave., Milwaukee, Wis. 53215.

Last year alone, over 400 power mower injuries were reported by Wisconsin physicians.[1] With the intensification of our mechanical age as evidenced in millions of households, women and children are frequent incidental but tragic victims. Since many of these accidents are domestic rather than industrial, it is natural that the patient, often with a detached appendage, is rushed to the local hospital emergency room for initial treatment. We are concerned in this paper with the immediate emergency room care of such a patient.

Prompt and skillful emergency treatment is absolutely essential for the patient with partial or complete amputation of an extremity. Anatomical restoration of an amputated extremity is admittingly rare and dependent upon many variable factors, but time remains essential in successful treatment of such cases. Technical surgical skills are important, but gratifying clinical results are relatively proportionate to how soon adequate blood supply can be restored to the traumatized tissue.

The main surgical principles of reconstruction of an amputated limb are: (1) the immediate reversal of the ischemic process, (2) prevention of vascular thrombosis, and (3) control of edema and infection. Without early revascularization, functional limb reconstruction is doomed to failure. Although admittingly not all patients with amputated limbs will be candidates for functional re-

plantation, until the degree of trauma and possibility of salvage can be professionally evaluated, such patients should be carefully treated as cases for potential surgical reconstruction.

Historically, more than a half a century ago, replantation of amputated extremities was successfully performed in laboratory animals.[2, 3] The first successful replantation of an amputated extremity in a human was reported in this country in 1964 involving an arm.[4] Although very few successful cases have been reported since that time, refined surgical techniques and modern high-speed transportation facilities for the transfer of such patients have resulted in more favorable conditions in attempts for surgical reanastomosis of amputated limbs.[5–7]

Replantation of partially amputated extremities frequently has been reported.[8, 9] An essential clinical factor of reanastomosis of a partially amputated limb is the preservation of arterial and venous continuity. If venous return is intact with the arterial anastomosis, successful results are more readily accomplished.[10]

Experimental data have consistently shown that with complete circulatory interruption of a limb, irreversible muscle damage occurs after 6 hours of ischemia.[11] Hypothermia and perfusion of an amputated extremity can extend this critical time up to 12 hours.[12] Laboratory studies of limb perfusion with oxygenated blood by a pump oxygenator and storage in a hyperbaric chamber show that this critical time factor may be increased.[13–15]

Definitive treatment of surgical candidates for limb replantation should begin immediately after admission to the hospital emergency room. After critical and life-endangering associated injuries have been evaluated, a conclusion must be reached on the feasibility of reanastomosing the severed limb. All amputated limbs will not be candidates for replantation! The main objective of a replantation attempt is restoration of limb function. Consequently, although vascular integrity may be preserved, the practicality of functional limb replantation is also dependent upon reconstruction of the traumatized bone, tendons, and nerves. A replanted limb cannot be considered practically successful unless motion can be relatively restored with or without an accompanying prosthesis.

Preservation of the vascular integrity of an amputated limb remnant can be started in the emergency room within minutes, giving the surgeon a time interval in which an evaluation of the patient can be made on the rational of limb salvage. The methods utilized for preserving the compromised circulation of an amputated appendage, although not standard, follow accepted principles in most trauma centers. The detached extremity should be cooled immediately by immersing in sterile ice water (0–4° C), and the vascular bed perfused with a cold, sterile, isotonic, intravenous solution.[16–18] The goals to be obtained by these measures are to decrease soft tissue metabolism, thereby protecting the limb from autolysis and bacterial growth, and to flush out any formed thrombi within the vessels.

Perfusion of a traumatized limb is preferably started by inserting a proper size polyethylene cutdown catheter into the largest of the transected arterial channels and allowing the perfusient to be flushed through the vascular bed. A polyethylene catheter is preferable to needle canalization so as to decrease damage to the already traumatized vessel walls.

A review of the current literature reveals that cold physiological saline or lactate Ringer's solution containing an anticoagulant and a nonirritating antibiotic, such as heparin and penicillin, appear to be the perfusing agents of choice. In addition, low molecular weight dextran may be used in small amounts in attempt to prevent further microthrombi within the peripheral channels. However, low molecular weight dextran should not be used alone as it will tend to dehydrate the extremity. Perfusion should be gravity fed and not forced, and perfusion time should not exceed 15 to 20 minutes as over-perfusion will cause extensive soft tissue edema. If facilities permit, this perfusion could be performed within a hyperbaric chamber at two to three atmospheres of pressure with the limb immersed in the aforementioned ice-cold sterile solution.

With early perfusion of the selected traumatized limb in the emergency ward, valuable time can be obtained to prepare the patient for definitive surgical treatment in the operating room. Instructions for management of such a patient should be specifically and periodically reviewed with all emergency room and operating room personnel. The

Fig. 1—(Case 1) Hemi-amputation of lower limb placed in apposition at the ankle prior to decision for reconstructive replantation.

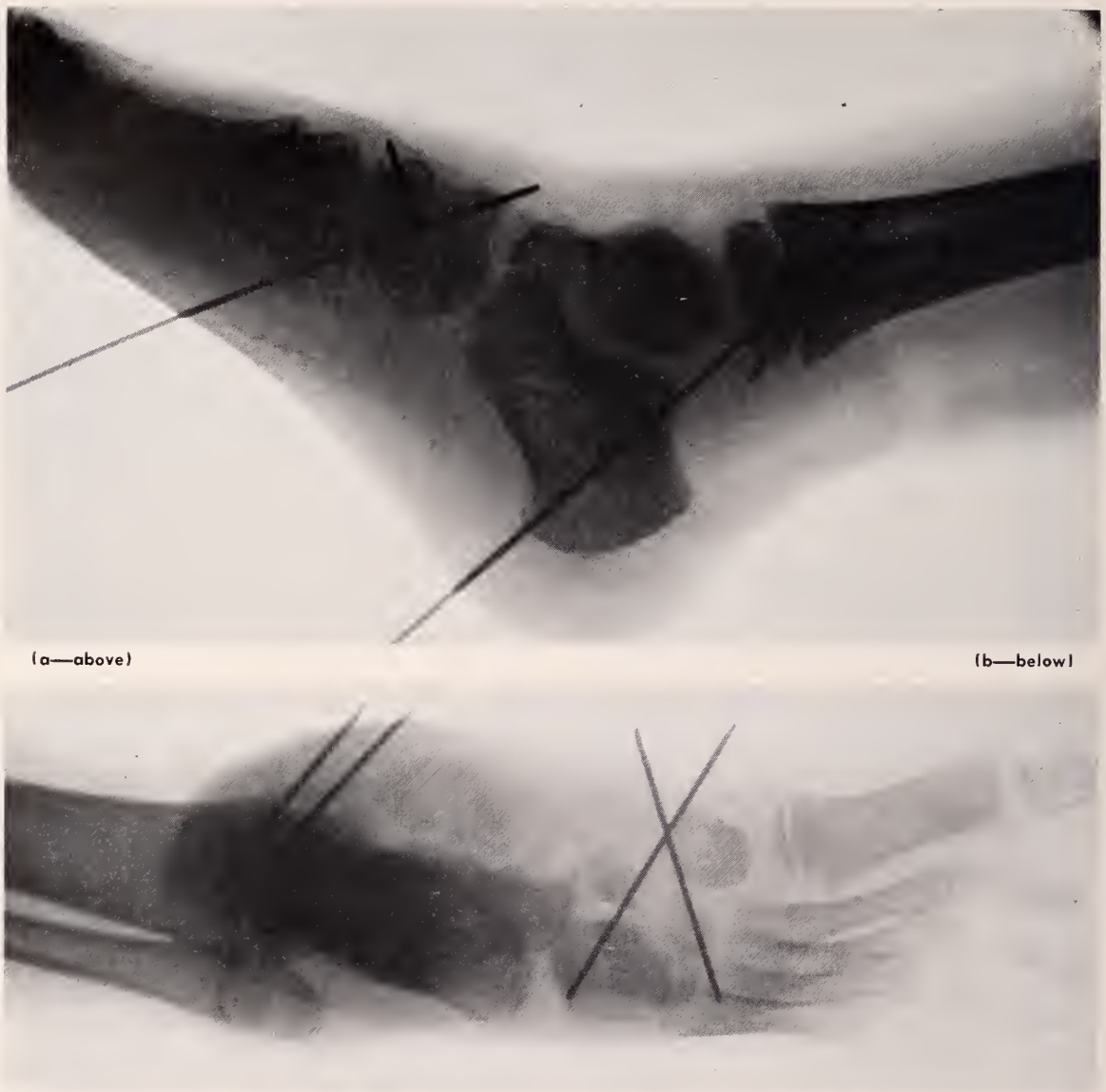
physician first seeing the patient in the hospital emergency room should be able to grasp the full significance of the necessity for the prompt care of the patient, as an individual with psychic and organic shock. He should realize that time works against both him and the patient. Preferably, a two-team emergency room physician approach should be employed: one administers to the needs of the patient and the traumatized stump in preparation for surgery while the other evaluates the degree of damage to the amputated segment and carefully considers if the conditions of trauma appear feasible for reconstructive surgery. The latter physician then can proceed with the proper care of preserving the amputated segment while the patient and operating rooms are being prepared. Sterile cutdown trays and refrigerated perfusing solutions can be kept on hand and the proper anticoagulants and antibiotic agents added as required. Simultaneously with the prompt and intensive care in the emergency unit, a team experienced in vascular and orthopedic surgery should be previously organized and on emergency call so that surgical replantation can be facilitated in optimum time. The following are two case reports in which selected traumatized appendages were prepared for successful surgical reconstruction.

CASE REPORTS

Case 1.—A three-year-old boy was admitted to the emergency room with a longitudinal hemi-amputation of the right foot and leg extending from between the second and third toes of the foot, through the ankle at the medial malleolus, Achilles tendon and the gastronemius muscle on the medial aspect of the lower right leg, sustained in a power mower accident (Fig 1). Emergency treatment for shock was carried out initially at the local county hospital, and the patient transferred for definitive care, with the amputated limb wrapped in a polyethylene bag of ice water, within one and one-half hours after the time of injury.

In the emergency ward, compression dressings were removed and the extent of trauma evaluated for reconstructive surgery. A small polyethylene catheter was placed into the largest arterial channel of the hemi-amputated limb remnant (medial malleolar artery) and a slow infusion of low molecular weight dextran was started. The remnant was placed in a sterile container with 1,000 ml of ice cold saline. In the interim, an intravenous solution of cold normal saline with 5,000 units of heparin and 1,000,000 units of aqueous penicillin was prepared. The low molecular weight dextran dripped at a slow gravity rate for approximately 5 minutes, and the infusion solution was then changed to the aforementioned saline preparation. After approximately 30 minutes of gravity perfusion, and while the operating room was being prepared, the stump showed good venous backflow.

In the operating room, utilizing a combined surgical and orthopedic team approach, the wound was extensively debrided and irrigated. Replantation was performed with Kirschner wire open reduction of the multiple fractures, reattaching the foot to the lower leg at the medial malleolus and stabilizing the cuboid-navicular bones of the foot (Fig 2a and b). Tendon, artery, and vein restoration was performed together with major nerve reanastomosis, but the smaller peripheral nerves were not reanastomosed. The limb replantation extended in a longitudinal line from an area medially below the knee, posteriorly through the Achilles tendon, across the medial malleolus and foot, and into the interdigital space between the second and third toes (Fig 3). The leg was dressed with compression dressings and immo-



(a—above) (b—below)

Fig. 2a and b—(Case 1) Kirschner wire stabilization of replantation at ankle.

bilized in slight plantar flexion with a posterior plaster splint.

Postoperatively, the patient was maintained on systemic antibiotics and had weekly dressing changes. Two weeks after surgery, the sutures were removed and a long leg plaster cast was applied for total immobilization of the limb. Eight weeks after surgery, the K-wires were removed and a short leg plaster cast with a walker was then applied. The patient was seen at regular monthly intervals and the cast removed six months after the injury. At this time, the patient had a viable limb with good dorsiflexion and external rotation (Fig 4). There was some weakness of internal rotation and a brace was prescribed for stability. Evaluation for ankle fusion was to be made at a later age if instability became a problem.

Case 2.—A 45-year-old housewife entered the emergency room with an extensive injury of the right hand as a result of a power mower accident. Examination disclosed severe bleeding with a shredded glove on the hand containing the multiple total and subtotal amputations of the index, middle, ring, and little fingers. The flexor and extensor tendons were completely severed with multiple compound fractures of the phalanges of all fingers and the metacarpals of the middle and ring fingers. The middle and ring fingers were completely amputated. The index and little fingers were connected by dorsal skin tag strands.

Emergency room treatment consisted of intramuscular administration of morphine, tetanus toxoid and procaine penicillin. The entire hand and amputated fingers were placed in a sterile basin containing ice cold saline solution. When a decision was reached to attempt reanastomosis of the severed fingers, a standard infant cutdown tray was opened and each

lateral digital artery was identified and meticulously cannulated with an infant scalp vein polyethylene catheter. One of the digital arteries of the little finger was so extensively traumatized that a catheter could not be inserted. Through these catheters, an infusion of cold sterile isotonic saline solution with 5,000 units of heparin and 1,000,000 units of aqueous penicillin was infused over a 20-minute period. During this time, routine laboratory tests were taken, and the operating room was prepared.

The metacarpal compound fractures were reduced under direct vision, and the multiple phalangeal fractures of the amputated digits were manually realigned in anatomical position. Fine Kirschner wires were drilled through the phalanges for reanastomosing the fingers and maintaining open osseous reduction. Arterial, flexor, and extensor tendons and digital nerve anastomosis was completed, and the hand immobilized in a position of function with a compression dressing. The Kirschner wires were cut at appropriate lengths and corks placed on the protruding ends (Fig 5).

Postoperatively, the patient was placed on large doses of parenteral antibiotics. The dressings were changed at seven-day intervals with encouraging viability of the amputated fingers evident at the first dressing change. Antibiotics were maintained for three weeks when the K-wires were removed from the index and middle fingers. The K-wires were removed from the ring and little fingers at five weeks. The patient was started on a passive physiotherapy course while still in the hospital 10 days after injury, and continued with progressive intensive physiotherapy treatments for approximately six months.

At the time of discharge from treatment, she had complete viability of all four traumatized fingers (Fig 6). Limitation of motion was primarily at the metacarpal-phalangeal joints of the ring and middle fingers where there was hypertrophied scar formation in the interdigital web between these fingers.

Fig. 3—(Case 1) Immediate postoperative appearance after replantation.

Fig. 4—(Case 1) Six months after successful replantation. Leg is viable and patient active with the use of an ankle and leg brace. The patient has full range of motion, with weakness on internal rotation.

Fig. 5—(Case 2) Postoperative appearance of replanted four amputated fingers of right hand.

The patient was doing her own housework without difficulty, and the soft tissues appeared well healed. She was able to place the thumb in apposition to the middle and index fingers and exerted a good pinch. At the time of discharge from physiotherapy, function of the hand was evaluated at approximately 65% normal motor capacity.

SUMMARY

A plea is made to establish a standard emergency room protocol for the treatment of patients with amputated limbs who may be candidates for replantation. Trauma of this type calls for immediate, rational, and mandatory treatment under a great time pressure. Emergency room personnel, house staff and attending physicians caring for such patients at the time of admission should be alerted that there is a definite and acceptable procedure for the preservation and preparation of limb remnants for reanastomosis. As time is the critical factor for limb reconstruction, the cardinal principle of emergency treatment is the preservation of the vascular integrity of the amputated limb. Therefore, with proper equipment and facilities, certain principles should be considered essential and adhered to in the emergency room treatment of patients with complete or incomplete amputated limbs.

There should be immediate evaluation and treatment of any associated life threatening injuries, and careful control of proximal stump hemorrhage. If replantation is practical on the basis of minimal contamination, ischemia, and anatomic destruction, the amputated limb should be immersed into ice cold sterile solution (0–4° C). Catheter perfusion of the major arterial channel of the amputated limb with a cold (0–4° C) isotonic solution, previously prepared and kept available in the emergency room refrigerator, should be started. To such a solution, 5,000 units of heparin and 1,000,000 units of aqueous penicillin should be added at the time of perfusion with acknowledgment of allergy made before adding these solutions.

It is hoped that with the aforementioned steps adequately carried out in the emergency room, critical time can be obtained for attempting limb replantation by an organized surgical team under optimum operating room conditions. With society's progressive industrial development and available high-speed transportation facilities, it is inevitable that more patients will be seen in the hospital emergency room with early complete or incomplete limb amputations. Heretofore, attempts at limb salvage have generally been rare. However, even minimal salvage in such cases is certainly an accomplishment that would justify alerting and putting to maximum use the capabilities and facilities of all hospital emergency rooms and their immediate personnel.

Fig. 6—(Case 2) Six months post-injury of complete and incomplete amputations of fingers of right hand with replantation. Motor functional capability 65% of measured normal.

ACKNOWLEDGMENT: We would like to acknowledge the assistance of Drs. Stewart Wilson and Joseph Szymarek in preparing the patients included in this paper for surgery.

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TELLS RESPONSE TO CLOMIPHENE

LONDON—Anovulatory patients with menstrual cycles of less than six months' duration are more likely to respond successfully to clomiphene therapy than those having longer cycles, according to Dr. David Ferriman of the North Middlesex Hospital, here.

The response to this therapy is also better in patients with polycystic ovaries than in those having ovaries of normal size, he adds.

Fifty-five anovulatory patients were treated with clomiphene citrate. Of these patients, 41 had been infertile or had had amenorrhea for more than two years. Nine of these 41 patients conceived after therapy.

Response to the treatment was found to be better in patients having basal estrogen excretions exceeding 21 μg/24 hours than in patients whose excretions fell below that level.

Various dosage schedules were used, ranging from 50 mg b.i.d. for five days to 100 mg b.i.d. for two weeks, Dr. Ferriman reports (Brit. Med. J. 4:444–446, 1967). Because no obvious advantages were found for the longer schedule, a standard dosage of 100 mg b.i.d. for five days was eventually used, and all patients received at least three courses of treatment before the investigators concluded that they would not benefit from the therapy.

Two associates of Dr. Ferriman at the North Middlesex Hospital participated in the study—Dr. Anthony W. Purdie, senior obstetrician and gynecologist, and Michael Corns, steroid chemist.

All patients in the study, Dr. Ferriman notes, were given a full medical and gynecological examination to rule out medical or gross gynecological disorders likely to be associated with menstrual disturbance or infertility. All kept basal temperature charts for at least six months before therapy and during treatment. Gynecography was performed in 51 patients.

Remarking on the odd finding that patients with polycystic ovaries respond better to clomiphene than those with normal-sized ovaries, yet have a lower conception rate, Dr. Ferriman conjectures that the "thickened capsule" of the larger ovaries "interfere with the release of ova, or that increased production of androgen by these ovaries impairs nidation."

An editorial comment on the clomiphene study at the North Middlesex Hospital (Brit. Med. J. 4:434–435, 1967) points out that it is useless to start clomiphene therapy "unless it can be established that the woman does not ovulate, is capable of ovulation, and has a fertile husband."

Gonadotropin assays are helpful in this determination, estrogen and pregnanediol assays are needed, and a semen analysis is mandatory, the editorial stresses. Diagnosis and therapy require a specialist clinic.

"Without the collaboration of such services, the use of clomiphene in general practice is clearly unwise," the editorial warns. "It is a fine example of a situation where the skillful use of laboratory resources can be of great benefit to a few people, while a failure to use them can do harm to a larger number," the editorial concludes.—From *Physicians International Press* as printed in OB. GYN. NEWS 3: 15 (Jan 15) 1968.

* * *

ON JAN. 1, 1968, a "lifetime reserve" of 60 additional benefit days was added to medicare hospital insurance which previously covered up to 90 days for each spell of illness.

Induction of Ovulation with Clomiphene Citrate

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■ THE SUCCESSFUL induction of ovulation with drugs is the most dramatic recent development in the treatment of infertility. A new drug, clomiphene citrate (Clomid), has undergone extensive clinical trials in more than 5,000 women during the past six years. After approval by the Food and Drug Administration, it became commercially available in May 1967.

Ten per cent of all marriages are involuntarily sterile, and in 25% of these failure of ovulation is a factor.[1] Until recently nothing could be done to promote fertility in most of these women.

OVULATION-INDUCING AGENTS

A placebo will induce ovulation in approximately 25% of anovulatory patients. Wedge resection of the ovaries in patients with the Stein–Leventhal syndrome has resulted in ovulation in 75% and pregnancy in 50% of patients. Corticosteroids often permit ovulation in patients with adrenal hyperplasia.

Low dose irradiation of the pituitary and ovaries, popular in the 1950s, was followed by ovulation in 70% and pregnancy in 30% of patients. The irradiation probably induced hyperemia, resulting in altered secretion by the glands. This approach was abandoned not because it was unsuccessful but because of fear of radiation damage. Estrogen and progesterone have been administered alone and in combination in an attempt to produce "rebound ovulation." Many women conceive during the first month after stopping oral contraceptives, but there is no significant difference if compared to women who discontinue mechanical methods of contraception, since in both situations the women tend to be hyperfertile.

The use of animal gonadotropins was popular in the late 1950s. Ovulation occurred in 15% to 25% of patients, which is no better than with a placebo, and severe anaphylactic reactions occurred.

Some patients undergo spontaneous remission of their infertility, but most have been destined to remain childless. Today most patients with anovulation can be treated successfully either with clomiphene citrate or with human gonadotropin isolated from human pituitary glands or from postmenopausal urine. In 1958 Gemzell first induced ovulation with human pituitary gonadotropin and human chorionic gonadotropin.[2] In 1960 Kistner and Smith reported successful induction of ovulation in four patients with Stein–Leventhal syndrome after the administration of a nonsteroidal estrogen antagonist, triparanol (MER-25), a substance closely related to clomiphene citrate.[3] Clomiphene is also structurally related to the estrogen chlorotrianisene (TACE), which has been used for many years (Fig 1).

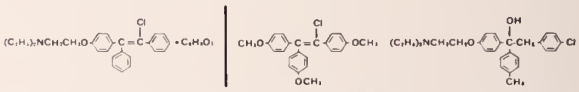

Fig. 1—Structural formulas.

Clomiphene citrate was first investigated as a possible contraceptive agent, but its value in inducing ovulation soon became apparent. In most cases clomiphene is preferable to pituitary gonadotropin because of its lower cost, ease of administration (oral instead of intramuscular), and lower toxicity. Clomiphene citrate costs about $5 to $10 per month, gonadotropin about $150 per month in usual doses. However, gonadotropin may be effective in patients clomiphene fails to help. Gonadotropin administration results in ovulation in 95% and pregnancy in 60% of patients.

MECHANISM OF ACTION

The exact mechanism by which clomiphene citrate induces ovulation remains obscure.

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Clomiphene is known to be antiestrogenic; after its administration there is first a fall in estrogen, followed by a rise in total urinary estrogen and luteinizing hormone. This suggests that clomiphene, by its antiestrogenic effect, inhibits estrogen feedback to the pituitary and allows the pituitary to release increasing amounts of follicle-stimulating and luteinizing hormone.

Clomiphene citrate may, however, induce ovulation in patients who are already hypoestrogenic; e.g., those with Chiari–Frommel syndrome. This suggests that clomiphene acts directly on the hypothalamic-pituitary axis, instead of on the ovaries.[4] It is possible that both mechanisms are responsible. However, recent investigations have questioned both hypotheses.

ADMINISTRATION

The exact dose of clomiphene citrate depends on the type of patient being treated and upon the sensitivity of the ovaries. Originally, when more than 1200 mg were given per treatment cycle, side effects were common.[4] For the usual patient the Food and Drug Administration has advised 50 mg daily for five days, starting five days after the onset of a menstrual period. If the patient is amenorrheic, a period should be induced by intramuscular administration of 100 mg of progesterone. If ovulation does not occur and there are no serious side effects after the first month, the dose should be increased to 100 mg daily for five days. This second cycle of treatment may begin as early as 30 days after the first. In a patient with Stein–Leventhal syndrome, it is advisable to give 100 mg of clomiphene for one day only because the ovaries are extremely sensitive and may respond by formation of multiple large cysts.[5] Ovulation usually occurs in the first or second treatment cycle; 75% of patients who respond do so in the first month.[4] The safety of long-term treatment has not yet been established; therefore, patients who have not responded after three consecutive treatment cycles should probably discontinue therapy.

Ovulation usually occurs between the fifth and tenth day after the last dose; patients should be instructed to have intercourse every other day during this period of time. A careful pelvic examination should be performed prior to each course of treatment to exclude ovarian cysts; the basal body temperature should be recorded daily to avoid giving another course of clomiphene after the patient is already pregnant.

TABLE 1— *Side Effects of Clomiphene Citrate*

1. Visual disturbances
2. Liver toxicity
3. Hot flashes
4. Alopecia
5. Skin rash
6. Headache and dizziness
7. Multiple pregnancy
8. Unnecessary surgery
9. Ovarian hyperstimulation

SIDE EFFECTS

Table 1 summarizes clomiphene's side effects. Visual disturbances including blurred or double vision and flashing lights have occurred in approximately 2% of patients. Most ocular symptoms have been reversible, but their occurrence remains a matter of great concern, in view of the production of cataracts by triparanol during its vogue as a hypocholesteremic agent. Some investigators have advised slit lamp examination of all patients before treatment. The patient should be warned that if visual symptoms occur, they can make driving and other activities hazardous.

Hepatic disease contraindicates the use of clomiphene, which is excreted through the biliary system. Hepatic function studies should always precede the use of the drug.[4]

Hot flashes occur in approximately 10% of patients, probably due to the antiestrogenic effect of clomiphene.

Loss of scalp hair occurs infrequently and has always been reversible. Skin rash, headache, and dizziness have occurred.

Multiple pregnancy, mostly twins, occurs in about 15% of reported pregnancies following clomiphene[6] and in about 50% of patients conceiving after gonadotropin treatment. With the latter, many are triplet, quadruplet, and quintuplet births with a high mortality due to prematurity. Patients should be informed of the incidence and hazards of multiple births.

Clomiphene produces abnormal endometrial histology which can lead to misdiagnosis of neoplastic disease and unnecessary hysterectomy. The gynecologist may unnecessarily remove a hyperstimulated ovary or resect a corpus luteum of pregnancy.[4]

TABLE 2—*Etiology of Anovulation*

- I. Central factors
  - A. Psychogenic
  - B. Neurogenic
  - C. Hypothalamic
    - 1. Tumors
    - 2. Congenital and destructive lesions
      - a. Chiari-Frommel syndrome
      - b. Sheehan's syndrome
      - c. Simmonds' disease
- II. Intermediate factors
  - A. Chronic disease
  - B. Nutritional
    - 1. Malnutrition
    - 2. Obesity
  - C. Metabolic disease
    - 1. Thyroid disease
    - 2. Diabetes mellitus
    - 3. Adrenal disease
      - a. Cushing's syndrome
      - b. Addison's disease
      - c. Adrenogenital syndrome
      - d. Tumor
- III. Ovarian factors
  - A. Tumors
  - B. Congenital
    - 1. Dysgenesis
    - 2. Agenesis
  - C. Destructive lesions
    - 1. Infection
    - 2. Radiation or surgical castration
  - D. Polycystic ovarian disease (Stein-Leventhal syndrome)
  - E. Premature menopause

Of 2 patients receiving gonadotropin treatment, one developed femoral arterial thrombosis, requiring amputation of the leg, and the other died from thrombosis of the internal carotid artery.[1]

The greatest danger of both clomiphene and gonadotropin is hyperstimulation of the ovaries.[1] This is more likely with the use of gonadotropin. The ovarian hyperstimulation syndrome in its minor form includes ovarian enlargement, lower abdominal pain and distention, nausea, and general malaise. In its most severe form it includes massive enlargement of the ovaries, which may reach the diaphragm, ascites, hydrothorax, and, rarely, a severe ileus-like syndrome. The ascites may lead to hypovolemic shock. The ovarian cysts may rupture, occasionally with fatal hemorrhage; this usually follows careless pelvic examination.

Hyperstimulation can usually be avoided by using clomiphene in small doses for short periods of time. The patient should be warned to report any abdominal pain promptly. Pelvic examination should be done frequently and carefully to check for ovarian cysts. Adequate rest periods should be allowed between courses of treatment, and the drug should not be repeated until the ovaries have returned to normal size. Patients with Stein–Leventhal syndrome or a history of ovarian cysts are more likely to develop hyperstimulation and should be given small doses of clomiphene.

Initial treatment of the ovarian hyperstimulation syndrome should be conservative.[1] The cysts usually disappear within 10 to 14 days. Some investigators have hastened their disappearance by giving an estrogen-progestin combination. Laparotomy should be reserved for signs of ovarian necrosis or intra-abdominal bleeding.[1]

INDICATIONS

Clomiphene citrate is indicated primarily for anovulatory patients with adequate endogenous estrogen but inadequate cyclic stimulation by pituitary gonadotropin. Adequate endogenous estrogen can be detected by vaginal smear, by endometrial biopsy for proliferative endometrium, or by eliciting withdrawal bleeding with progesterone. A typical patient who will respond to clomiphene has adequate endogenous estrogen, normal or slightly increased 17-ketosteroids, normal thyroid function, and normal or slightly decreased follicle-stimulating hormone.[7] The ideal patient is one with secondary amenorrhea and normal endocrine studies, which would include patients with Stein–Leventhal syndrome.

Patients with failure of ovulation usually present with one or more of the following complaints: dysfunctional uterine bleeding, amenorrhea or oligomenorrhea, and infertility. Table 2 summarizes the etiology of anovulation.

PRETREATMENT EVALUATION

Candidates for treatment with clomiphene citrate should be thoroughly studied to reduce treatment failures and to identify patients in whom toxicity is likely to develop.

Even after extensive study, a specific cause for anovulation is seldom found; usually we are left with a diagnosis of a disturbance in the hypothalamic-pituitary-ovarian axis, or simply a "hormone imbalance." If a specific cause of anovulation is found, the cause should be treated.

Table 3 lists the essentials of an adequate examination which should precede administration of drugs used to induce ovulation. Anovulation should be diagnosed from basal body temperature records, endometrial biopsy, and possibly pregnanediol determination. Presence of endogenous estrogen should be established. Pituitary gonadotropins, 17-ketosteroids, and ketogenic steroids should be determined; tests of thyroid and liver function should be done. Skull x-ray films should be taken for visualization of the sella turcica, and visual fields may be indicated to assist in excluding pituitary neoplasm. Patients with primary amenorrhea should have a buccal smear for sex chromatin determination. Married patients should have complete infertility studies, including semen analysis, hysterosalpingogram and Huhner test.

Culdoscopy is usually advisable if Stein–Leventhal syndrome or ovarian dysgenesis is suspected. Dilatation and curettage should be done in patients with abnormal bleeding to exclude carcinoma.

RESPONSE TO TREATMENT

A positive response to treatment; i.e., a presumptive diagnosis of ovulation, can be detected most easily from the basal body temperature chart and the endometrial biopsy. At ovulation the basal body temperature should rise 0.6 to 0.8 F, and the elevation should be maintained for at least 10 days. Menstruation should occur 12 to 16 days after the rise in temperature appears.

Basal body temperatures are not completely reliable because a temperature rise may occur in the absence of ovulation. The endometrial biopsy is more accurate. It may be taken on the first day of menstruation or several days earlier. A third index of ovulation is a rise in urinary pregnanediol from the preovulatory level of approximately 1 mg/24 hours to 2–7 mg/24 hours. It is interesting to note that 40% of patients who respond to clomiphene experience "mittleschmerz."[4] Neither clomiphene nor gonadotropin will restore permanent normal ovarian function, although occasionally a second ovulatory cycle may follow an ovulation induced by the drug.[1]

Clomiphene is most effective in idiopathic secondary amenorrhea and Stein–Leventhal syndrome. It is less effective in treating varying degrees of ovarian and pituitary failure.

TABLE 3—*Pretreatment Evaluation Before Administration of Ovulation-Inducing Agents*

1. Basal body temperature	9. PBI
2. Endometrial biopsy	10. BSP
3. Pregnanediol	11. Skull film
4. Vaginal smear	12. Visual fields
5. Progesterone withdrawal	13. Buccal smear
6. 17-Ketosteroids	14. Semen analysis
7. 17-Ketogenic steroids	15. Hysterosalpingogram
8. FSH	16. Huhner test
	17. Culdoscopy
	18. D & C

In one series 70% of patients ovulated and nearly 30% became pregnant. This was not an accurate index of pregnancy since 10% of the patients were single, some did not desire pregnancy, and many were treated for only one or two cycles. Infertility was the fault of the husband in some cases. In another study 45% of 165 married women conceived following clomiphene therapy.[4] There is no evidence that clomiphene causes an increased incidence of congenital malformations. The incidence of spontaneous abortion has been about 18%. However, abortion is normally more common in women with a history of infertility, approaching 25%.

If a patient fails to respond to treatment she should be reevaluated with follicle-stimulating hormone (FSH) determination, culdoscopy, skull films, visual fields, and sex chromatin determination. Patients with primary ovarian failure will have an elevated FSH level; patients with ovarian failure secondary to pituitary failure will have low or absent FSH.

OTHER USES OF CLOMIPHENE

In one series of 8 patients with galactorrhea, all had good suppression of lactation with clomiphene citrate therapy.[6] It has been suggested that clomiphene might be useful in regulating ovulation so that the rhythm method of contraception might be used more effectively. However, this has not proved practical, and the possible benefits are outweighed by the risk of multiple pregnancy.

In a normally ovulating woman, clomiphene causes a delay in ovulation. This property was used to advantage in a patient who presented as an infertility problem because for religious reasons she avoided intercourse during the week following her menstrual period. Because of a short menstrual cycle,

ovulation was occurring during the week of prohibited coitus. Clomiphene was administered to delay ovulation, and she became pregnant during the first treatment cycle.

Seven patients with an inadequate luteal phase lasting only 9 to 11 days were treated with clomiphene. After treatment 6 patients had an increase in the luteal phase to 14 to 25 days.[8]

Clomiphene citrate, 100 to 200 mg/day for 30 to 60 days, was given to 3 children with precocious puberty. The anti-estrogenic effect of the drug produced regressive changes in the vaginal mucosa of all 3 children.[8]

Reversal of endometrial hyperplasia and endometrial carcinoma in situ has been reported following clomiphene treatment.[9] The effect is only temporary because the drug is incapable of correcting the basic defect. Clomiphene has produced regression in several cases of metastatic breast carcinoma. There is some evidence that clomiphene may improve spermatogenesis in oligospermic males.[10]

SUMMARY

Of several agents proposed for induction of ovulation in infertile women, clomiphene citrate (Clomid) is the most practical agent presently available. Its mechanism of action remains obscure. The recommended dose is 50 to 100 mg daily for five days, starting five days after the onset of a menstrual period. Ovulation usually occurs 5 to 10 days after the last dose. Clomiphene has induced ovulation in nearly 80% of women with idiopathic anovulation with a subsequent pregnancy rate as high as 45%. The most important side effect is ovarian hyperstimulation.

Candidates for treatment with clomiphene citrate should be studied thoroughly to eliminate patients who will not respond and to recognize patients who are likely to develop serious side effects. Physicians using this drug should have a thorough understanding of infertility and be familiar with the recognition and treatment of clomiphene's potentially fatal complications.

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EFFECT OF HYPERVENTILATION ON PRECORDIAL T-WAVES OF CHILDREN AND ADOLESCENTS

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Following the recording of 12-lead routine electrocardiograms, three precordial leads were recorded before, during and after 10 to 15 seconds of voluntary hyperventilation in 296 students, ranging in age from 8 to 17 years.

Fifteen per cent of the total group, comprising 212 Caucasians and 84 Negroes, inverted one or more previously upright precordial T-waves following hyperventilation. The incidence of T-wave inversion in children 12 years and under was nearly four times greater in Caucasians than in Negroes. There was no significant difference when the older Negro and Caucasian students were similarly compared. Sinus tachycardia, T-wave flattening, and "tucking"*, short of frank inversion, as well as junctional depression of the S T segment, were commonly seen following hyperventilation.

The T-wave inversion observed in electrocardiograms of children and adolescents was similar to that previously documented in adults. The clinical implication of this study is that physicians should always remain aware of the occurrence of "nonpathological" T-wave inversion in all age groups in order to avoid iatrogenic heart disease.

* The term "tucking" is used to describe a predominantly upright T-wave with a notch or depression at its summit or terminal segment, which may or may not pass below the isoelectric line.

The Use of Clomiphene Citrate (MRL-41; Clomid) for the Induction of Ovulation (Treatment of 81 Patients in 422 Cycles)

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■ THE GYNECOLOGIC endocrinologist sees many patients with complaints related to anovulation. These complaints generally are of two types, either those of (1) abnormal vaginal bleeding, which covers the spectrum from amenorrhea to excessive bleeding; and/or (2) infertility. If the complaint is only that of abnormal bleeding and if the possibility of malignancy has been excluded, these patients can be best treated with the cyclic replacement of ovarian hormones (estrogen and progesterone). However, if the patients' complaint is infertility due to the lack of ovulation, the physician must try to determine the specific cause for the anovulation and correct it. Many cases will be found in which no specific etiology is found or where specific treatment is not available. This is the group of patients suitable for treatment with the new drug, clomiphene citrate (Clomid).* It is the purpose of this report to describe the results of 422 cycles of treatment with clomiphene in a series of 81 patients with amenorrhea-oligomenorrhea.

METHODS

The patients described were attending the Gynecologic Endocrine Clinic at the University of Minnesota. It was determined desirable to attempt to induce ovulation either to correct the complaint of infertility, or to determine the function of the hypothalamic-pituitary-ovarian axis. Each patient had a complete history and physical examination and she was then admitted into the hospital for a complete endocrine evaluation. The testing procedures have already been described.[1] Briefly, this included the collection of the total daily urine output for the measurement of 17-ketosteroids, 17-hydroxycorticoids, and total gonadotropin excretion; the measurement of plasma cortisol at 8 AM and 8 PM to indicate the circadian level variations; a standard ACTH, metyrapone (Metopirone), and human growth hormone test; x-ray examinations of the chest and skull; blood protein bound iodine (PBI), electrolytes, fasting blood sugar (FBS), cholesterol, and complete blood count (CBC); vaginal smear for cornification count; endometrial biopsy; and frequently culdoscopy and gynecography. All of the patients were instructed on the taking of daily Basal Body Temperatures (BBT). These were recorded daily during the study.

After the diagnostic classification of the patient was established, she was treated specifically to correct any diagnosed abnormality; for example, thyroid in hypothyroidism or insulin for diabetes mellitus.

If there was no abnormality other than gonadotropin and/or estrogen deficiency, or if there was no ovulation following specific treatment, the patients were then treated with clomiphene. The drug was given in a uniform dosage of 50 mg tablets twice a day for 5 days. At the end of the month the patient was reexamined. All treatment cycles were with the same dosage schedule. At each visit, a record was made of any side reactions to the medication that the patient volunteered; patients were not questioned specifically concerning the occurrence of side effects.

The criterion of success was the establishment of ovulation. The evidence of ovulation was either pregnancy, or the combination of (1) a biphasic BBT pattern with (2) subsequent vaginal bleeding; and (3) at least one endometrial biopsy showing a secretory pattern.

Presented at the 126th Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, May 10, 1967.

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* Clomiphene citrate was generously supplied as Clomid by Dr. John E. Johnson, Jr. of the William S. Merrell Company of Cincinnati, Ohio.

RESULTS

A total of 81 patients were treated in 422 cycles. The mean age for the group was 24.3 years (15–32). The results are summarized in Table 1. In this group, 58 patients (72%) were classified as ovulating in a total of 238 cycles (56%). It is noteworthy that 53% of the patients who ovulated did so in the first treatment cycle. There were 22 (37%) pregnancies in the group of 59 potentially fertile females. This eliminated the single patients and also those whose husbands had less than 20 million sperm/ml in a masturbation ejaculate. Of the 22 pregnancies, 6 are undelivered. The 16 delivered patients had four (18%) abortions, three sets of fraternal twins (14%), and seven singleton deliveries. There were five male and ten female infants. There were no anomalies detected in the infants.

Eighteen (22%) of the patients reported side effects, the most frequent one being hot flashes during the days of drug ingestion. Also, 5 patients (6%) complained of "blurring vision," which ranged from difficulty with accommodation to after-vision. No anatomic abnormalities could be detected in any of these patients. Also noted were 5 patients with ovarian cysts, 2 patients with "mittelschmerz," 2 patients with nausea, and 1 patient developed mild alopecia.

A somewhat more helpful analysis of the results involves a division of the patients into broad diagnostic groups (Table 1). There were 3 patients with primary amenorrhea and they were treated in 25 cycles without any response. There were 78 patients with secondary amenorrhea of a mean duration of 2.7 years (0.25–16 years). The patients with secondary amenorrhea were divided into three subgroups. One patient had both galactorrhea and polycystic ovaries. The first of these were those with a diagnosis of polycystic ovaries or the Stein-Leventhal syndrome. These patients had all of the stigmata of the syndrome. Ten patients previously had bilateral ovarian wedge resections and the histologic sections were compatible with the diagnosis but the operation failed to induce ovulation permanently. There were also 8 patients with similar findings but they only had culdoscopy and gynecography demonstrating enlarged polycystic, thick capsuled ovaries and they had not had ovarian wedge resections. The total of 18 patients were treated in 94 cycles. Fifteen (83%) of the patients ovulated in 82 (87%) of the treatment cycles. Again, the majority of the patients (14 or 78%) ovulated in the first treatment cycle. Eight pregnancies (47%) occurred in this group.

Another subgroup of secondary amenorrhea included those patients with an associated galactorrhea. Here, 8 patients were treated in 36 cycles and 6 (75%) of the patients ovulated in 21 (58%) of the cycles. There were also 3 (37%) of the patients who became pregnant. There was no change in the galactorrhea.

The final subgroup was the largest and this involved the remaining 53 patients with secondary amenorrhea. They were treated in 269 cycles and 38 (72%) patients ovulated in 136 (51%) of the cycles, again with 27 (51%) ovulating in the first treatment cycle. In this group there were 12 (33%) pregnancies.

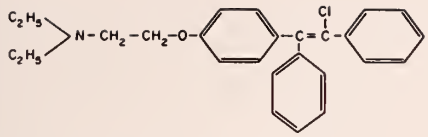
DISCUSSION

The induction of ovulation in the infertile female has always been a problem for the gynecologist. Many forms of treatment have been advised but they have not been uni-

TABLE 1—*Summary of treatment results with a uniform dosage of clomiphene citrate*

Classification	Number Patients	Cycles of Treatment	OVULATION			Pregnancies
			Number Patients	Number Cycles	Number in First Cycle	
Total Group	81	422	58 (72%)	238 (56%)	43 (53%)	22 (37%)
Secondary Amenorrhea Stein-Leventhal Type	18*	94	15 (83%)	82 (87%)	14 (78%)	8 (47%)
Galactorrhea	8	36	6 (75%)	21 (58%)	3 (37%)	3 (50%)
All other	53	269	38 (72%)	136 (51%)	27 (51%)	12 (33%)
Primary Amenorrhea	3	25	None	None	None	None

*One patient had both Stein-Leventhal syndrome and galactorrhea.



1-[p-(β-diethylaminoethoxy) phenyl] 1,-2-diphenyl-2-chloroethylene

Fig. 1—Structural formula for clomiphene citrate (Clomid).

versally used either because of their inadequacy, expense, inconvenience, or dangers.

In 1961 Greenblatt et al described the use of clomiphene.[2] This drug is a synthetic, nonsteroidal, nonhormonal chemical whose structure is shown in Figure 1. The chemical is antiestrogenic and has no action on the adrenal or thyroid gland.

The probable site of action seems to be at the hypothalamic level. The antiestrogenic effects cause a release of gonadotropin releasing factors (RF) which in turn produce the dysfunctioning pituitary gland to release gonadotropin (FSH) and this then stimulates the ovarian follicles. The follicles produce estrogen and this stimulates pituitary LH release and ovulation. Experimental hypothalamic implantation studies by Igarashi et al in the rat are in agreement with this theory.[3] Mishell, with serial urine determinations has shown a delayed rise in LH excretion following clomiphene administration, and several other investigators with random samples have shown a rise in the urinary gonadotropin excretion after giving the drug.[4] This theory is given further support by the data of Kistner who noted that in clomiphene failure cases, ovulation could be induced if clomiphene treatment was followed by chorionic gonadotropin (LH-like) injections.[5]

The side effects noted with the use of clomiphene have generally been numerous but not serious and they tend to be dose related. The most commonly reported ones are hot flashes and ovarian cysts, each with a mean incidence of about 15%.[6] Other rarer side effects noted included gastrointestinal disturbances, blurring vision, and alopecia.[7] It is also noted that there is frequently multiple ovulation with an increased incidence of multiple pregnancies. The drug is metabolized in the liver and should, therefore, not be given to the patient with liver disease. The side effects noted in this series are in agreement with those reported by others.

The reported overall success with this drug is a 69% ovulation rate and a 30% pregnancy rate.[6] These results are in agreement with other published series.

Three clinical points can be made from the present data. First, the patients with primary amenorrhea generally respond poorly to clomiphene. This is probably a reflection of the high incidence of abnormally formed ovaries that are present in this group of patients. These ovaries are not able to respond to gonadotropins. Secondly, all of the secondary amenorrhea groups had at least a 50% ovulation rate. This now gives the clinician an excellent therapeutic tool for the induction of ovulation. It should be noted that most of these patients who are going to ovulate do so during the first treatment cycle. Until a better selection method is available, one should consider a therapeutic course of three cycles of treatment in all of these patients since the hazards of treatment are low and the success rate is high. It is also hoped that newer endocrine tests of the hypothalamic-pituitary axis will enable the gynecologic endocrinologist to better select those patients who are not likely to have a successful result from treatment. Such studies are currently underway in our laboratory.[8] Finally, it has been disconcerting that the pregnancy rate in most treated series is so much lower than the assumed ovulation rate. Several possible explanations for this discrepancy exist, for example, either the presumptive signs of ovulation (BBT, bleeding, and endometrial biopsy) are inaccurate and ovulation has not occurred, or perhaps this discrepancy is a demonstration of the complexity of fertility and that ovulation alone does not guarantee a normal implantation.

SUMMARY

Eighty-one anovulatory patients with primary (3 patients) or secondary (78 patients) amenorrhea were treated with clomiphene citrate, 50 mg twice a day for 5 days per month, for a total of 422 cycles. Ovulation occurred in 72% of the patients and pregnancy occurred in 37%. None of the 3 patients with primary amenorrhea ovulated. This form of treatment for the gynecologic endocrine patient is discussed.

ACKNOWLEDGMENT: The author would like to thank Dr. W. D. Cohen for his steroid studies performed on these patients.

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CARCINOMA OF THE BREAST IN CHILDREN

Guillermo Ramirez, MD and Fred J. Ansfield, MD, Division of Clinical Oncology, University of Wisconsin Medical School, Madison, *Arch Surg* 96: 221–225 (Feb) 1968

Carcinoma of the breast is uncommon in children. Some reports indicate an incidence of 0.09% or less of all of the mammary cancers occur in patients under the age of 20. The youngest patient reported was 3 years old. In most of the cases, the main finding was a painless nodule, almost always found near, although discrete from, the nipple. Occasionally, some of the metastases were noted before the primary site was discovered. In a few instances, the appearance of a tumor was associated with trauma. The histological pattern did not differ significantly from that in the adult breast cancer and the natural history of the disease varied. Although the majority of the cases occurred before puberty, no clear evidence of hormonal dependence was demonstrated.

This is a report of an 11-year-old girl, admitted to University of Wisconsin Hospitals July 6, 1966, with the chief complaint of back pain of three weeks' duration. Two years before this admission, enlargement of both breasts was noticed, but it was attributed to early signs of sexual development. One month prior to admission, patient experienced dyspnea on moderate exertion.

Physical examination revealed an 11-year-old girl in a mild degree of respiratory distress, enlarged lymph nodes were found in both axillae and in both inguinal areas. Both breasts were enlarged and several hard masses were felt. No hepatomegaly was found and pelvic examination was normal. Smears taken from the vaginal mucosa indicated no estrogenic activity. Chest roentgenograms showed pulmonary and mediastinal metastases of the lymphogenous type. X-ray films of the spine showed osteoporotic bones and pathological compression fractures of D6 and D10.

Laboratory studies included normal urinalysis, hematocrit and WBC of 8,100 with a normal differential. The alkaline phosphatase was 20, K-A units. A biopsy was taken from one of the axillary nodes and a diagnosis of anaplastic carcinoma was made.

Since no estrogen stimulation was seen, oophorectomy was not felt to be indicated and instead, aggressive combination therapy with chlorambucil, 6 mg/day, orally, methotrexate 5 mg/day orally and dactinomycin 10 micros/kg/day was given. To prevent further collapse, focal radiation therapy was given to D6 and D10. Significant regression of the breast masses was noted, with some improvement in the pulmonary lesions. This response was maintained for five months, when reactivation occurred and therapy with cyclophosphamide was given. Again some improvement was noted, but the patient deteriorated very rapidly and died nine months after the tumor was diagnosed.

JUVENILE PAPILLOMATOSIS

L. B. Newberg, MD, H. C. High, MD, R. H. Lehman, MD, and T. T. Tang, MD,: *Arch. Otolaryng.* 86:681–684 (Dec) 1967.

A case history of a 2 year old boy who suddenly asphyxiated following occlusion of his tracheostomy tube is discussed. A diagnosis of laryngeal papillomata was made at 7 months of age; multiple direct laryngoscopies with superficial excision of the papillomata did not prevent recurrences and tracheostomy was performed for tracheal occlusion.

At autopsy, inspissated mucous secretions blended with desquamated mucous debris occluded the distal end of the tracheostomy tube. Papillomata were implanted on the tracheal mucosa at the entrance of the tracheostomy tube and near the bifurcation around the tip of the cannula. The glottis was blocked by papillomata. The pathological diagnosis was papillomatosis.

The likelihood of extention of the papillomas from trauma and seeding has been found to be more frequent in the tracheostomised patient consistent with the viral etiology of papillomas.

The possibility of tracheal and bronchial involvement should be considered in all recurring cases of juvenile papillomas. The diagnosis of papillomatosis can be confirmed by bronchography or bronchoscopy or both. Treatment consists of bronchography with excision of the growth.

From the departments of Otolaryngology and Pathology, Marquette School of Medicine, Milwaukee Children's Hospital, and the Veterans Administration Hospital, Wood, Wisconsin.

Therapeutic Dilemmas

No. 5 of a Series

Editor:

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COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner periodically in the WISCONSIN MEDICAL JOURNAL.

MALLORY–WEISS SYNDROME

Moderator: DOUGLAS D. KLINK, M.D.

Participants: DUANE MAYHEW, M.D.
FREDERICK W. MADISON, M.D.
NICHOLAS L. OWEN, M.D.
DONALD SHAW, M.D.
WAYNE BOULANGER, M.D.
D. H. WINSHIP, M.D.

Dr. Douglas D. Klink: Our subject this morning is a disease which, though itself of relatively rare occurrence, must always be given serious consideration in determining the therapeutic approach to acute gastrointestinal hemorrhage. Doctor Mayhew will present the protocol.

Dr. Duane Mayhew (Intern): The patient, a 62-year-old white businessman, was admitted to the hospital on March 7, 1967. On the night prior to admission he had experienced nausea and vomiting, which he attributed to the eating of a large number of peanuts. The next afternoon he was seen by his physician, who prescribed prochlorperazine (Compazine). The patient then went back to work, where it was said that he had an emesis of old blood and later one of fresh blood. He was then seen in the Outpatient Department and admitted to the hospital at 9:45 PM, which was about 24 hours after the vomiting had begun.

On admission the physical examination was essentially unremarkable and the medical history noncontributory except that the patient, who operates a liquor store and does not now smoke or drink, had been a heavy drinker until a few years prior to this episode. Temperature was 99.2 F. Pulse rate 88 and regular. Blood pressure 140/70 mm Hg. Hemoglobin 14.0 gm/100 ml, hematocrit reading 40%.

Early on the morning following admission the patient fainted while attempting to void, and during the day he vomited blood again and had several black stools; the abdomen became distended. He received 6 units of blood during this day. The next morning at 7:30 he had a 200-ml bloody emesis and a second one at 3:30 PM. Five more units of blood were given on this day. The hemoglobin fell continuously until it reached 7.4 gm/100 ml, and the hematocrit reading was 22% when exploratory laparotomy was performed at 4:45 PM. The coagulation panel was normal except for a very low platelet count before operation.

Other laboratory studies: catheterized urine specimen, "slightly hemolytic staphylococcus and coagulase-negative Staphylococcus epidermitidis"; fasting blood sugar, 134 mg/100 ml; BUN, 50 mg/100 ml; blood creatinine, 1.4 mg/100 ml; liver function panel, normal. The patient's postoperative course was essentially uneventful, and he was discharged on March 23, 1967.

Dr. Klink: I should mention that the blood sugar determinations done in this hospital are all plasma and not whole blood sugars because of the use of the autoanalyzer. Are there pertinent x-ray films?

Dr. Donald Shaw (Resident in Roentgenology): We only have two postoperative chest films. The air seen on the left side of the descending aorta in this case is surgical emphysema. The same finding on an upright chest film preoperatively would be suggestive of esophageal rupture.

Dr. Klink: It is notable that about 48 hours elapsed between the time of the patient's admission with a good hemoglobin and his coming to surgery with a hemoglobin of 7 gm/100 ml. I wonder if Doctor Madison could tell us something about the occurrences during this period?

Dr. Frederick W. Madison: We do not have definite evidence that the patient had blood in the early vomiting between the eating of the famous peanuts and his calling upon Doctor Owen for medical help on the afternoon of the second day. The first hemorrhage of record occurred in his store, and

it was apparently massive according to his wife, who also worked in the store. He then continued to bleed moderately and was admitted at 9:45 that evening, as already stated. Doctor MacKay did a rectal examination in the Outpatient Department and found no blood or stool. When I saw the patient thereafter he looked very well, was having no distress of any sort, and wanted to go home. But we admitted him, and the next day he continued to vomit blood and the hemoglobin dropped sharply, as already remarked. A total of 11 units of blood was administered prior to operation. Throughout this period we were monitoring the patient with a complete coagulation panel, and were thus assured that we were not dealing with any sort of hemostatic defect. Despite the large amount of blood that had been transfused, the only significant hematologic alteration was a considerable drop in platelets.

Dr. Nicholas L. Owen: I really do not know whether this patient had blood in his vomitus from the beginning. When I saw him in his home he was very frightened, and I think he might well have withheld admission of the blood loss if it had occurred. He told conflicting stories about it after entering the hospital.

Dr. Klink: Well, we know that ultimately he *did* bleed, if not at once, then when the vomiting began. It was this continuing and copious bleeding that brought Doctor Boulanger into the case.

Dr. Wayne J. Boulanger: In discussing the differential diagnosis with Doctor Madison on the day of surgery, we concluded that probably there had been a laceration at the cardioesophageal junction. Gastrointestinal x-ray studies were not done because these tears are not demonstrated in this way, and we considered it very unlikely that we were dealing with esophageal varices. I did not consider endoscopy because my experience with it has been unrewarding in people who are bleeding as rapidly as this man.

A long gastrotomy was done and we could see arterial bleeding pouring down from above but were unable to locate the bleeding site at once. The stomach was found to be full of clot but not bright red blood. Finally, by carefully ironing out the mucous membrane of the esophagus between fingers, we found, at a point just above the cardioesophageal junction, a little piece of blood clot protruding from the bottom of a fold; and when we pulled out this clot there was brisk arterial hemorrhage from a laceration about 1.5 cm long. Treatment consisted of placing a running Dacron lock stitch, beginning at the bottom of the laceration so that we could pull down on it as we worked our way up; it was necessary to enter the chest to obtain satisfactory exposure of the lesion. In a similar case three weeks earlier I had to open the esophagus.

In 1929, G. Kenneth Mallory, then an assistant in pathology at the Boston City Hospital, and Soma Weiss, an assistant professor of medicine at Harvard, reported (Hemorrhages from lacerations of cardiac orifice of stomach due to vomiting, *Am J. Med. Sc.* 178:506, 1929) 15 cases of this syndrome in alcoholic debauchees. Four of the five patients who were described in detail had died and come to necropsy, and in all of them there were lacerations in the cardia of the stomach, extending in one instance up into the esophagus. These observers found ulcerations in the mucosa extending as deep as the muscularis, with a covering of fresh fibrin and exudate of polys. We did not see this sort of thing in our living patient. One of their patients had died but had never bled; and, curiously, all of their lacerations were multiple. All the lacerations I have seen have been single, which seems to be the general experience; in reviewing the 36 patients surgically treated by several reporters during the preceding 18 months, John J. Byrne and John M. Moran (The Mallory–Weiss syndrome, *New Eng. J. Med.* 272:398, Feb. 25, 1965), at the Boston City Hospital, said that single lacerations were described in 21, 2 in 8, 3 in 6, and 5 in 1 case.

Mallory and Weiss postulated that the tear was simply a pressure phenomenon during the act of vomiting, and they produced such tears in a cadaver specimen from an individual who had not manifested this syndrome. In substantiation of this, M. Atkinson's group (Mucosal tears at the esophagogastric junction [Mallory–Weiss syndrome], *Gut* 2:1, 1961) established that in normal retching adults the intragastric pressure often exceeded the 150 mm Hg that they found sufficient to cause the lacerations in cadaver stomachs.

In a recent report from the Cook County Hospital, R. J. Freeark and associates (Mallory–Weiss syndrome: increasing surgical significance, *Arch. Surg.* 88:882, 1964) mentioned 2 patients, in a series of 13, who reported a "tearing" sensation with their

vomiting, and in one of these there was laceration through the muscularis of the cardia, with extensive subserosal hematoma. In this situation you could get a sausage-like esophagus with blood between the mucous membrane and the wall; I suppose this sort of dissecting hematoma could cause obstructive symptoms if it organized enough. Total ruptures of the esophagus have also been reported without hemorrhage.

At the Brooke Army General Hospital, K. D. Holmes (Mallory–Weiss syndrome: review of 20 cases and literature review, *Ann. Surg.* 164:810, 1966) recently reviewed 20 cases of this syndrome, which they found to be 5% of their upper gastrointestinal bleeders. Fifteen of the 20 patients had been drinking, and esophagogastroscopy (which, with an early GI series, is routine in Army hospitals) demonstrated the typical lesion in 17; 2 of the other 3 were diagnosed at operation and the other 1 at necropsy. In the 3 instances in which the Sengstaken–Blakemore tube was tried it failed; and none of the x-ray studies demonstrated the lesion.

Doctor Madison asked me how often the bleeding stops spontaneously in these cases and I told him that it never stops in the ones that I see, else I should probably not see them! But I do think it likely that many of the gastrointestinal hemorrhages that we sign out here with etiology undetermined may actually be cases of the Mallory–Weiss syndrome. None of the patients operated upon at Brooke General Hospital bled again. Apparently the suturing treatment is generally satisfactory. However, when this malady is complicated by gastric ulcer, it is possible to operate for the ulcer and miss the bleeding point.

In summary, it is important to distinguish this lesion from bleeding varices, and to use endoscopy if the endoscopist is quick enough to escape the blood that rushes into the scope. X-ray study will help in finding varices but not the lesion of the Mallory–Weiss syndrome. The Sengstaken–Blakemore tube is of no value. It must be particularly remembered that this lesion lies down in a fold of the mucosa and cannot be found unless these folds are ironed out by the surgeon's fingers, particularly if there is not active bleeding at the time of the exploration. It is apparent from the record that simple suturing is adequate treatment.

Dr. Klink: Thank you, Doctor Boulanger. We are privileged to have with us this morning Doctor D. H. Winship, Assistant Professor of Medicine at Marquette School of Medicine and gastroenterologist at the Milwaukee County General Hospital, who will continue the discussion. Perhaps he will touch upon the use of the ice water lavage as well as the use of the Sengstaken–Blakemore tube in this malady?

Dr. D. H. Winship: It is unreasonable to expect the Mallory–Weiss lesion to respond to esophageal tamponade with the Sengstaken–Blakemore tube since this is arterial bleeding. We cannot inflate the esophageal balloon on this tube to more than 40 mm Hg because of the very real danger of inducing necrosis, and the arterial pressure will surpass this, so the patient will continue to bleed unless he is in profound shock with tremendously reduced peripheral pressure. I personally do not know of a single case in which this sort of tamponade has been helpful.

Colonel Eddy Palmer published a few years ago (Sources of upper gastrointestinal hemorrhage in cirrhotic patients with esophageal varices, *New Eng. J. Med.* 248: 1057, 1953) the results of his vigorous diagnostic approach, employing panendoscopy, upper GI series, and whatever else he could think of to do at the moment in patients actively bleeding from the upper gastrointestinal tract. The striking thing in this large series of patients was that those who had esophageal varices—not necessarily bleeding from these varices, but who had them—often had another serious gastrointestinal lesion also from which they could bleed. So then you must consider that the individual with the Mallory–Weiss syndrome, who is likely to be alcoholic and therefore to have esophageal varices, may also have other potentially hemorrhagic lesions, such as gastritis, gastric ulcer or duodenal ulcer. And thus the diagnostic, and by inference the therapeutic, difficulties become great.

Actually, not all the Mallory–Weiss patients are alcoholics. Mallory and Weiss assumed them to be so because all of their original patients were. But then they encountered the typical lesion in a young woman with hyperemesis gravidarum who was not alcoholic; and nonalcoholics have been seen by others. In fact our present patient was not recently alcoholic at least. However, most cases that are definitely diagnosed are in individuals who drink excessively.

I suppose that as a gastroenterologist I would be expected to say that endoscopy is the diagnostic answer. But I do not think that this is so because in my experience it has often been disappointing. When the lesions are in the stomach they are in an area that cannot be seen with the esophagoscope and only with great difficulty with the gastroscope. And if in the esophagus, they are in the distal portion where there is a mass of longitudinal folds with the lesion or lesions in a crypt of these folds. The small, linear lesions are frequently bleeding vigorously, and though it is possible to advance a sponge ahead of the tip of the instrument, this technic will permit visualization of the lesion in only a small proportion of instances in my experience. But since the therapy will differ strikingly whether the patient has hemorrhagic gastritis, bleeding esophageal varices, or the Mallory–Weiss syndrome, it is likely that endoscopy should be attempted in selected cases.

In a recent article, by A. E. Dagradi and associates (The Mallory–Weiss lesion: an endoscopic study of 30 cases, *Gastrointes. Endosc.* 13:18, 1967), in Los Angeles, reported making the diagnosis of Mallory–Weiss syndrome in 22 of 30 cases through either esophagoscopy or gastroscopy. It is notable, however, that the bleeding subsided spontaneously in most of their patients, which leaves the inference that perhaps it had not been as vigorous as that we encounter in the type of patient who eventually comes to surgery, as did our patient today and most of those we see.

Now a word about the use of vigorous ice water lavage. I think this is often worthwhile, at least initially if for no other reason than to gain a little time in which to transfuse the patient to a better level. I have never seen a case, however, in which imminent surgery was averted by this technic. Brisk arterial bleeding from the esophagus is perhaps least effectively treated. There are enthusiastic reports of the usefulness of the measure in bleeding esophageal varices, but I have found it only moderately or even minimally effective in the longrun.

Dr. Klink: Thank you, Doctor Winship. Are there questions?

A Physician: Do these Mallory–Weiss patients have pain at the time of the bleeding?

Dr. Boulanger: In the case presented this morning there was no pain experienced so far as we could learn. And in the patient I mentioned having seen a few weeks ago there was vomiting three times without bleeding before bloody emesis began, and no pain at any time.

Dr. Madison: To amplify that answer I would say that when pain occurs it usually means that the esophagus has ruptured and we have the Boerhaave, and not the Mallory–Weiss, syndrome to deal with. The absence of pain classically serves to differentiate these two maladies.

A Physician: What is the likelihood that the patient who has been bleeding massively still has a normal coagulation panel? And what is the effect of copious transfusions on the panel?

Dr. Madison: I cannot envision a situation in which hemorrhage per se will deplete coagulation factors to a point of clinical significance, although it is true that in relatively rare instances there will be a reduction in platelets, as there was in the present case. The question of the effect of large amounts of banked blood upon the coagulation panel is a complex one. Admittedly, we are always concerned in such situations with the possibility, particularly if there is to be surgery, of increasing the likelihood of hemorrhage through an induced loss of blood coagulability. We do not know precisely what it is that brings this about, but since it will not occur if fresh blood is used in place of banked blood, there is a strong inference that with banked blood one introduces an anticoagulant substance that may be in sufficient amount to cause trouble if multiple transfusions are given during a short period. The element of time is important here; it is not the total quantity of blood transfused that poses the threat so much as the fact of introducing the units in rapid succession.

A Physician: What are the complications of endoscopy in this situation?

Dr. Winship: Ordinarily, the patient who is bleeding massively is very frightened and hence fully cooperative. Under such circumstances the likelihood of getting into difficulties—through perforating the esophagus, for example—is very small. But in the patient in whom we are suspecting the Mallory–Weiss syndrome there may also be the state of agitation that frequently characterizes the alcoholic; in fact, the patient may be in or near delirium tremens. Under such circumstances the risk of dire consequences is of course tremendously increased. I feel that

the procedure should be considered contraindicated in any noncooperative patient.

Dr. Klink: Just two short questions. Should the individual who is bleeding be deeply sedated? And would vasopressin (Pitressin) be indicated in approaching the diagnosis of Mallory–Weiss syndrome?

Dr. Winship: No one has been able to show that sedation is effective in altering any of the objective parameters of peptic ulcer, but the use of sedatives is certainly a humane measure in any patient who is made greatly apprehensive by his bleeding. Pitressin, too, may be useful, particularly as a differential tool. The arterial bleeding of the Mallory–Weiss syndrome will not be affected by it, but since the drug rapidly and strikingly decreases portal venous pressure through decreasing splanchnic blood flow, it will lessen the bleeding from esophageal varices. Therefore, if there is other reason for suspecting the presence of esophageal varices, the use of Pitressin may provide evidence in support of the presumptive diagnosis, and in any case is unlikely to be harmful.

A Physician: In choosing his operative approach is it helpful to the surgeon to know beforehand that the patient definitely has the Mallory–Weiss syndrome?

Dr. Boulanger: The answer is definitely yes, because if it is known beforehand that the bleeding is from the esophagus, one is able to choose a higher site for the necessary gastrotomy. If we ultimately are going to do a 50% to 75% gastric resection, we would prefer not to have that vertical suture line in the gastric pouch to introduce some sort of T-configuration and perhaps cause some difficulty in wound healing.

Dr. Klink (summarizing): The Mallory–Weiss syndrome, constituting 5% to 10% of upper gastrointestinal hemorrhage, is characterized classically by initial bloodless vomiting followed by painless bloody vomiting. The highest incidence (80%–90%) is in adult, often alcoholic, males. Bleeding is due to laceration of the mucosa high in the stomach, low in the esophagus, or at the cardioesophageal junction. In perhaps 75% of cases the bleeding is capillary or venous, and may stop spontaneously or respond to simple measures, including ice water lavage. In the remaining 25% it is arterial, and prompt surgery is the only effective therapy. Differential diagnosis includes bleeding from esophageal varices and ulcer. Endoscopic and x-ray studies are difficult in these cases but may occasionally be helpful. The Sengstaken–Blakemore tube will not stop arterial bleeding but might aid in diagnosis. Pitressin may also be useful in differentiating this bleeding from that of esophageal varices. Coagulation studies are very important in ruling out hemorrhagic diseases and in preparation for surgery. Properly diagnosed, and promptly treated, there should be no mortality in the uncomplicated cases.

TREATMENT OF BURNS WITH INTENSIVE THERAPY AND EXPOSURE

G. E. Collentine, Jr., MD et al, Milwaukee, Wis.: *JAMA* 200:939–942, 1967.

Results of treatment of 500 consecutive burned patients with very large doses of antibiotic prophylaxis, both parenterally and topically, have been encouraging.

In partial- and full-thickness burns involving more than 25% of the body surface, daily intravenous administration of 6 Gm. chloramphenicol (Chloromycetin), 6 to 8 Gm. sodium methicillin (Staphcillin), 10 million units potassium penicillin G, and 10 ml. gamma globulin, is begun *on admission* and continued for 3 weeks or longer if coverage is delayed. Polymyxin B, 75 to 100 mg., is added to the regimen when good urine output is established. Intramuscular gentamicin sulfate, 80 mg. per day, has been used with pseudomonas infection is observed.

The burn surface is "dabbed" 6 to 8 times daily with cotton pledgets soaked in a saline solution containing 1 Gm. of chloramphenicol, 0.5 Gm. of neomycin sulfate, 0.1 Gm. of polymyxin B and 500,000 units of mycostatin/liter.

Of 60 deaths, 17 (28%) were attributed to sepsis and 9 to renal failure. No deaths were considered associated with the antibiotic therapy *per se*, or due to superinfection because of this early therapy. Drug reactions were few and none were thought to be significant. Very frequent blood cell and reticulocyte counts, electrolyte and urea nitrogen determinations were performed during intensive antibiotic therapy.

When mortality was related to age and extent of burn and compared with that report by 8 major burn centers, data from this burn center indicated the results of this regimen equal or superior to any being currently obtained elsewhere. A plea is made for more publication of statistical analyses of large burn treatment series and the establishment of team care centers.

Abstract from *Surgery Digest*, November 1967.

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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An Approach To Antibiotic Therapy

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SINCE INFECTION is seen in virtually every type of medical practice, it is imperative that the physician develop a habit of approaching the problem in a practical, stepwise manner. As Jawetz[1] has pointed out, such an approach involves answering three basic questions. First of all, does the patient suffer from a microbial infection? If so, what is the clinical diagnosis: tonsillitis, pneumonia, septicemia, meningitis, endocarditis? Secondly, what is the most likely microorganism causing the infection? Finally, which available antimicrobial drug will be most effective in eradicating the etiological microorganism? The answer to the second question may have to be a "best guess" inasmuch as it is not always practical, or even possible, to pinpoint the causative agent before initiating therapy.

If the patient has a serious infection requiring hospitalization, the available laboratory facilities must be used to establish a definitive bacteriologic diagnosis. A properly performed Gram stain can be a valuable guide in selecting the most effective antibiotic regimen. Since the invading bacteria may be present in blood, sputum, stool, urine, or wounds, these multiple sources should be cultured depending upon the type of infection that is suspected. Occasionally the results of in vitro sensitivity test are helpful such as in the reevaluation of the initial antibiotic regimen. In general, using the clinical "best guess" and the Gram stain, the physician can follow a scheme as shown in Table 1 to select a suitable drug aimed at the etiological microorganism.

Before initiating antibiotic therapy, it is necessary to consider several other factors as follows: (1) previous history of hypersensitivity reactions, (2) potential side effects, (3) daily dosage, (4) route of administration, and (5) duration of therapy. In less serious infections the cost of a drug can also be an important consideration. For brevity, only the most pertinent points will be emphasized in the following discussion.

Group A Beta-hemolytic Streptococcus—tonsillitis, pharyngitis, otitis media, lymphangitis, scarlet fever.

All strains of the group A beta hemolytic streptococci continue to be extremely susceptible to penicillin G. In the absence of a history of hypersensitivity this antibiotic is always the drug of choice. Ten to 14 days of treatment is required to eliminate the organism and prevent attacks of rheumatic fever and nephritis. A single injection of 900,000 units of benzathine penicillin G (Bicillin) will result in adequate blood levels for this period. When oral penicillin V is administered in a dosage of 250,000 units four times daily, it must be emphasized that the medication be continued even though the acute symptoms have subsided.

Alpha-hemolytic Streptococcus (Viridans)

The major importance of this organism is its role in subacute bacterial endocarditis. At the present time, approximately half of all cases of bacterial endocarditis are caused by the Streptococcus viridans. Aqueous penicillin G should be administered parenterally in a dosage of 2.4 to 6.0 million units daily for four weeks. It is an accepted practice to give intramuscular streptomycin in a dosage of 0.5 gm twice daily for the first two weeks.

Enterococcus (Streptococcus fecalis)

In contrast to the above mentioned streptococci, the enterococcus is relatively resistant to penicillin G.

URINARY TRACT INFECTION: This can be caused by this organism alone or in combination with gram-negative bacilli. Acute uncomplicated infections, caused by the enterococcus, E. coli, or Proteus mirabilis, generally respond well to 2.0 to 4.0 gm of oral ampicillin given daily for ten days. Since ampicillin is a semisynthetic penicillin, it should not be prescribed for patients known to be allergic to penicillin G.

ENDOCARDITIS: The incidence of enterococcal endocarditis has increased in the past decade. This organism is the causative agent in 10% to 15% of all

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TABLE 1—*Antimicrobial Drugs of Choice*

Infecting Organism	First Choice	Alternative Choice
Gram-positive cocci		
Streptococcus (beta) Group A	Penicillin G	lincomycin, erythromycin
Streptococcus (alpha) viridans	Penicillin G (with streptomycin)	cephalothin
Enterococcus	Penicillin G (with streptomycin)	ampicillin, erythromycin
Pneumococcus	Penicillin G	lincomycin, erythromycin
Staph. aureus		
non penicillinase-producers	Penicillin G	cephalothin, erythromycin
penicillinase-producers	Nafcillin (Unipen) Oxacillin (Prostaphlin, Resistopen) Methicillin (Staphcillin)	cephalothin, lincomycin, vancomycin
Gram-negative cocci		
Meningococcus	Penicillin G	sulfonamide, ampicillin, cephalothin
Gonococcus	Penicillin G	erythromycin, cephalothin
Gram-negative bacilli		
E. coli		
sepsis	Chloramphenicol (with streptomycin)	kanamycin, cephalothin
urinary	Ampicillin (Polycillin, Penbritin)	sulfonamide
Klebsiella	Cephalothin (Keflin)	chloramphenicol (with streptomycin)
Aerobacter	Kanamycin (Kantrex)	chloramphenicol (with streptomycin)
Proteus mirabilis	Ampicillin	cephalothin, chloramphenicol (with streptomycin)
Indole + proteus	Kanamycin	chloramphenicol (with streptomycin)
Pseudomonas	Polymyxin B	colistimethate (Colymycin)
Hemophilus influenza		
respiratory	Ampicillin	tetracycline
meningitis	Ampicillin	chloramphenicol

cases of bacterial endocarditis seen today. The recommended treatment consists of 20 million units of intravenous aqueous penicillin G daily given in combination with 0.5 gm of intramuscular streptomycin twice daily for a period of six weeks. The additive effect of these two drugs against the enterococcus is well known.

Pneumococcus

The pneumococcus, like the group A beta hemolytic streptococcus, continues to be extremely susceptible to penicillin G.

LOBAR AND BRONCHOPNEUMONIA: A patient with uncomplicated pneumococcal pneumonia will be afebrile 18 to 36 hours after receiving a regimen of 400,000 units of aqueous penicillin G administered intramuscularly every eight hours. The drug can be discontinued after the fifth day of treatment.

MENINGITIS: The pneumococcus may invade the subarachnoid space by direct extension from otitis media, mastoiditis, paranasal sinusitis, or a skull fracture that communicates with the nasal cavity. In addition, the organism may reach the meninges as a result of bacteremia secondary to an underlying pneumonia. Despite the sensitivity of the pneumococcus to penicillin G, the mortality rate for pneumococcal meningitis remains approximately 30%. All age groups are susceptible. A minimum dosage of 12.0 million units of aqueous penicillin G should be given daily by the parenteral route. In children and most adults, therapy can be discontinued after 10 to 14 days.

Staphylococcus

The incidence of severe staphylococcal infections has decreased since the introduction of the penicillinase-resistant penicillins in the early 1960s. Although several effective agents are now available, most staphylococcal infections respond slowly because of the tendency for the organism to cause abscess formation. A proper approach to therapy must consider both specific antibiotic therapy and the need for adequate surgical drainage. Methicillin was the first commercially available penicillinase-resistant penicillin; thus, it has undergone the most extensive clinical study. However, both nafcillin and oxacillin have greater activity against penicillin G sensitive bacteria and the penicillinase-producing staphylococci. When used properly all three antibiotics are equally effective.

SOFT TISSUE (CELLULITIS, FURUNCLE, CARBUNCLE): Superficial infections are best treated with moist heat and incision and drainage of local lesions. Cellulitis, lymphadenitis, and rapidly spreading lesions require the administration of oral oxacillin, 2.0 to 3.0 gm every 24 hours, for 10 to 14 days.

PNEUMONIA: Staphylococcal pneumonia, characterized as a "carbuncle on the lung," is often accompanied by rapid tissue necrosis, abscess formation, and the production of purulent secretions. An adequate airway should always be maintained. In serious staphylococcal infections it is reasonable to assume that the organism is resistant to penicillin G and therefore to initiate therapy with a penicillinase-resistant penicillin. Parenteral nafcillin or oxacillin in doses of 1.0 gm every four hours should be administered until the infection appears under control. The oral route can then be utilized and the therapy continued until the chest roentgenogram has cleared or stabilized. Four to six weeks of total therapy is usually required.

OSTEOMYELITIS: Initial therapy for acute osteomyelitis should be nafcillin or oxacillin in parenteral doses of 4.0 to 6.0 gm daily. Treatment should be continued for 14 to 28 days. A poor response always raises the question of abscess cavities in bone or soft tissue. Occasionally, chronic osteomyelitis will respond to long-term oral therapy.

ENDOCARDITIS: At the present time, the staphylococcus is the causative agent in approximately 25% of all cases of bacterial endocarditis. Because of extensive clinical experience with methicillin, this drug remains the treatment of choice in this most serious infection. An intravenous dose of 12.0 to 24.0 gm given daily for six weeks is recommended. The more precise dosage of the antibiotic for the individual patient can be determined by following the tube dilution sensitivities and bacteriocidal levels.

SEPTICEMIA: If there is no evidence of endocarditis, blood stream invasion by the staphylococcus can be treated with 1.0 gm of nafcillin or oxacillin administered parenterally every four hours for a minimum of four to six weeks. Additional therapeutic measures aimed at the primary source of infection (i.e., drainage of pus) may be an important determinant in the outcome of treatment. In the patient known to be allergic to penicillin G, life-threatening staphylococcal infections can be treated with vancomycin in doses of 1.0 to 1.5 gm given intravenously over a 30 to 40 minute period every 12 hours. Cephalothin is highly active against both penicillin G-sensitive and resistant strains of staphylococci and can be administered as an alternative drug in a parenteral dosage of 1.0 gm every four hours. Because of the similarity between the basic molecules of cephalothin and penicillin, approximately 12% of patients who are allergic to penicillin will develop hypersensitivity reactions to cephalothin.

Meningococcus-meningitis.

Strains of meningococci isolated since about 1963 have shown an increasing incidence of sulfonamide resistance. For this reason, aqueous penicillin G is currently the drug of choice and should be administered parenterally in a dosage of 12.0 million units daily. Treatment can usually be discontinued after 7 to 10 days.

Gonococcus-urethritis, pelvic inflammatory disease.

The amount of penicillin G necessary to cure most cases of gonorrhea has continued to increase over the years. Many centers are now giving a single injection of procaine penicillin, 2.4 million units to males and 4.8 million units to females (half the dose in each buttock).

Enteric Gram-negative Bacilli

URINARY TRACT INFECTIONS: Approximately 80% of all urinary tract infections are caused by E. coli. Most of these infections occur in young or middle aged females. Although there is a wide choice of effective agents, it seems reasonable to employ a bacteriocidal drug such as ampicillin. The daily oral administration of 2.0 to 4.0 gm of this antibiotic is effective and should be continued for 10 days. Obstructive uropathy, instrumentation, and previous antibacterial therapy may set the stage for infection with other more resistant gram-negative bacilli. The more serious infections arising from these circumstances are best treated with a combination of intravenous chloramphenicol, 4.0 gm daily, and intramuscular streptomycin, 0.5 gm every 12 hours, for a period of 10 days.

BACTEREMIA: E. coli, Proteus, Klebsiella–Aerobacter, and Pseudomonas usually gain entry to the blood stream from urinary tract infections. Occasionally, the portal of entry is ascending cholangitis, peritonitis, gangrene, burns, pneumonia, or a venous cutdown. Treatment cannot be withheld awaiting the results of blood culture. Therefore, an antibiotic regimen must be administered that will be active against most of these possible pathogens. A combination of chloramphenicol and streptomycin as outlined for acute urinary tract infections is satisfactory. Intravenous cephalothin, 6.0 gm daily, and intramuscular streptomycin, 0.5 gm every 8 to 12 hours, is equally effective. If renal function is adequate, initial therapy can be intramuscular kanamycin, 1.5 to 2.0 gm per day. When the bacteremia is known to be caused by Pseudomonas, the drug of choice is polymyxin B in a dosage of 30 to 50 mg administered intramuscularly every six hours. Patients, suspected of having gram-negative bacteremia, must be observed closely for signs of circulatory collapse.

Hemophilus Influenza-meningitis.

Although H. influenza can cause severe respiratory infection in children, its major importance in this age group is the tendency to cause meningitis. Chloramphenicol, given intravenously in a daily dosage of 2.0 to 4.0 gm, is effective. Ampicillin is bacteriocidal for the three major etiological agents in meningitis: Hemophilus influenza, pneumococcus, and the meningococcus. Recent studies have demonstrated that ampicillin alone, given intravenously in a minimum dosage of 150 mg/kg body weight per day (in equally divided doses at four-hour intervals), is an excellent drug to initiate therapy for purulent meningitis of unknown etiology. The total duration of therapy required for H. influenza meningitis is in the range of 7 to 10 days.

In conclusion, it should be emphasized that, whenever a patient fails to respond to the initial antibiotic regimen, the physician must retrace his steps and again attempt to answer the three questions proposed at the outset of this paper. Several common examples of therapeutic failure are: (1) prescribing antibiotics for fever that is not infectious in origin, (2) the wrong choice of drug for the etiological microorganism, and (3) failure to recognize complications such as abscess formation or obstruction to normal drainage. In the rational management of patients suspected of having infection, the aforementioned approach can be of considerable value.

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SPECIAL TO THE JOURNAL FROM THE WISCONSIN DIVISION OF HEALTH

The 1966 Measles Epidemic Was Dampened If Not Prevented

By H. GRANT SKINNER, M. D., M. P. H. and WILLIAM L. GILBERT, B. Sc., Madison, Wisconsin

IN DECEMBER 1965, it was predicted that the prompt widespread use of the measles vaccine would prevent the expected measles epidemic in Wisconsin. Table 1 (see page 172) gives a fair idea of the coverage with the dates of the clinics. Since many of them were accomplished after 1966 began, their impact was not total. However, a decided dampening effect was noted and the real impact occurred in 1967 with 1,985 reported cases of measles.

During the last 11 years there have been two super-epidemics of measles in Wisconsin and three midpoint epidemics (Fig 1 and Table 2). The year 1966 would have been, except for the effect of widespread immunization with the new live measles vaccine, a super-epidemic year. Actually the 1966 measles cases added up to a low midpoint epidemic. It was followed in 1967 by the lowest measles year that was ever recorded in Wisconsin. Wisconsin children in 1967 had only 2.8% of the cases of the super-epidemic year and but 12.5% of the cases of the lowest measles year in the last 11 years.

This most desirable change is believed to be due in great part to the introduction of measles vaccine. Vaccination has been done by medical practitioners since 1963 and in community-wide measles vaccination programs which began in September 1966.

The community-wide measles programs were patterned on the Sabin Sunday Polio Clinics and had similar objectives. It was expected that vigorous, well publicized public programs would convince parents that the vaccine was valuable and also that these programs would vaccinate the backlog of measles-susceptible children in the community. Special emphasis was placed on the immunization of preschool children, although the program usually included susceptible children to the age of 12 years.

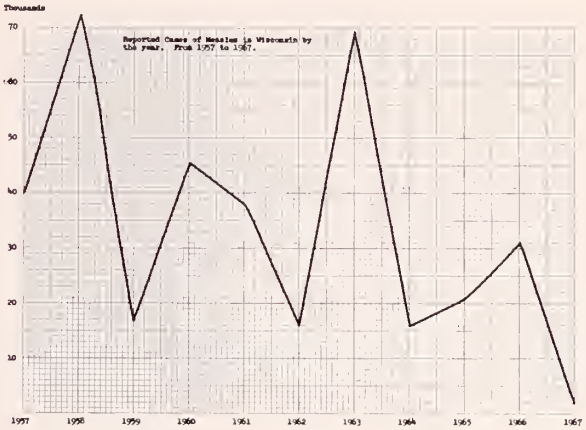

Fig. 1—Reported cases of measles in Wisconsin by the year: from 1957 to 1967.

As of Jan. 12, 1968, a total of 81,884 children had received live measles vaccine; of these children 44.9% were preschoolers. Under the measles program from June 1966 to December 1967, 35,467 doses of vaccine were supplied to practitioners. In addition, although we have no information on the amount used, a large number of doses of measles vaccine was administered by medical practitioners, both before the program began and subsequently.

The introduction of measles vaccine is well under way. Physicians and other health workers should be encouraged with the results to date.

TABLE 2—*Reported Cases of Measles in Wisconsin: 1957–1967*

Month	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967
January	1,425	7,394	1,131	1,948	4,575	873	9,783	597	1,046	4,803	256
February	2,717	6,636	1,496	2,326	5,441	660	11,894	1,218	1,186	6,270	240
March	6,655	11,377	2,026	6,313	7,891	817	14,292	2,928	1,951	7,444	312
April	5,602	18,564	2,306	8,295	7,311	1,034	17,649	4,363	2,379	4,469	268
May	8,894	14,861	2,383	8,981	7,817	2,169	8,933	3,497	3,697	3,908	247
June	6,058	8,899	2,118	8,792	2,798	1,539	4,177	1,535	3,617	2,338	161
July	2,601	3,146	1,511	2,770	926	861	1,027	538	1,317	581	79
August	756	419	511	882	278	483	219	133	446	212	83
September	397	275	384	279	153	286	198	190	191	133	76
October	700	360	320	425	181	1,071	228	194	477	133	88
November	1,107	301	668	1,327	382	2,375	181	375	1,316	253	103
December	3,121	761	1,705	2,185	387	3,876	237	636	3,448	231	72
Total	40,033	72,993	16,559	44,523	38,140	16,044	68,818	16,204	21,071	30,775	1,985

TABLE 1—*Community-Wide Measles Immunization Programs*

	Date	No. of Children Immunized		
		Preschool	School	Total
DISTRICT I				
*Columbia Co.	11-09-66	1,130	1,565	2,695
Dane Co.	10-23-67	521	1,114	1,635
Grant Co.	None			
Green Co.	Planned			
Iowa Co.	None			
Jefferson Co.	10-19-67	607	532	1,139
Lafayette Co.	None			
Rock Co.	06-13-67	917	1,312	2,229
Edgerton City	04-23-67	136	105	241
Sauk Co.	09-30-67	503	782	1,285
	Totals	4,976	5,578	9,554
DISTRICT II				
Kenosha Co.	12-03-67	1,621	2,483	4,104
Milwaukee City	Own Immunization Program			
Milwaukee Co.				
Village of Brown Deer	03-08-67	30	177	207
Village of Greendale	11-03-67	33	78	111
**City of So. Milwaukee	04-11-67	123	1,119	1,242
Racine Co.	11-05-67	2,199	995	3,194
Burlington City	10-08-67	421	435	856
Walworth Co.	None			
Waukesha Co.	Own Immunization Program			
	Totals	4,781	5,409	10,190
DISTRICT III				
Calumet Co.	None			
Dodge Co.	None			
Fond du Lac Co.	None			
Manitowoc Co.	05-17-67	409	2,819	3,228
Manitowoc City	05-17-67	395	2,459	2,854
Ozaukee Co.	None			
Sheboygan Co.	05-21-67	490	239	729
Sheboygan City	04-09-67	808	967	1,775
Washington Co.				
Germantown	03-23-67	128	86	214
Winnebago Co.	11-11-67	1,155	1,123	2,278
Winneconne City	06-01-67	215	168	383
Oshkosh City	10-15-67	1,482	1,165	2,647
	Totals	5,082	9,026	14,108
DISTRICT IV				
Buffalo Co.	10-29-67			
Crawford Co.	10-29-67	414	172	586
Jackson Co.	None			
Juneau Co.	12-10-67	272	96	368
La Crosse Co.	05-28-67	655	1,318	1,973
Monroe Co.	06-11-67	811	730	1,541
Pepin Co.	05-07-67	395	355	750
Richland Co.	04-30-67	185	202	387
Trempealeau Co.	None			
Vernon Co.	08-27-67	360	275	635
	Totals	3,092	3,148	6,240
*Columbia Co.	03-10-67	162	168	330
**City So. Milwaukee	05-12-67	354	122	476
Make-up Programs		(Included in Totals Above)		

	Date	No. of Children Immunized		
		Preschool	School	Total
DISTRICT V				
Adams Co.	04-21-67	176	274	450
Clark Co.	09-19-67	874	1,054	1,928
Green Lake Co.	04-15-67	412	160	572
Marathon Co.	None			
Marquette Co.	02-17-67	160	380	540
Portage Co.	09-23-67	970	990	1,960
Waushara Co.[1]	11-25-66	439		439
Waushara Co.	05-24-67	216	63	279
Wood Co.	06-03-67	1,411	1,343	2,754
	Totals	4,658	4,264	8,922
DISTRICT VI				
Brown Co.	05-06-67	860	646	1,506
Green Bay City	05-06-67	2,944	2,664	5,608
Door Co.	09-09-67	419	519	938
Kewaunee Co.	09-13-67	673	614	1,287
Menominee Co.	03-07-67	85	57	142
Marinette Co.	10-10-67	798	1,868	2,666
Oconto Co.[2]	11-12-66	300	67	367
Outagamie Co.	09-16-67	1,581	1,637	3,218
Seymour City	04-29-67	270	311	581
Shawano Co.	05-03-67	298	2,666	2,964
Waupaca Co.	06-10-67	900	1,131	2,031
	Totals	9,128	12,180	21,308
DISTRICT VII				
Barron Co.	None			
Burnett Co.	09-18-67	115	109	224
Chippewa Co.	06-28-67	623	538	1,161
Douglas Co.	None			
Dunn Co.	05-09-67	488	533	1,021
Eau Claire Co.	None			
Pierce Co.	12-05-67	125	954	1,079
Polk Co.	Planned			
Rusk Co.	None			
St. Croix Co.	02-02-68	656	713	1,369
(With Pierce Co.)	02-03-68	277	83	360
Sawyer Co.[3]	03-15-67	170	353	523
Washburn Co.[4]	12-15-66	298	322	620
	Totals	2,752	3,605	6,357
DISTRICT VIII				
Ashland Co.	02-27-67	305	350	655
Bayfield Co.	04-24-67	138	28	166
Florence Co.	01-25-68	64	218	282
Forest Co.	01-26-68	230	355	585
Iron Co.	04-26-67	79	243	322
Langlade Co.	02-23-67	46	91	137
Lincoln Co.	11-20-66	626	1,138	1,764
Oneida Co.	12-16-67	298	235	533
Price Co.	02-27-67	358	13	371
Taylor Co.	None			
Vilas Co.	01-27-68	144	246	390
	Totals	2,288	2,917	5,205
TOTALS—All Districts		36,757	46,127	81,884

[1]Epidemic Control Program.
[2], [3], & [4]Not Assisted by State Division of Health.

THE PRESIDENT'S PAGE

HAROLD J. KIEF, M.D.

The Corson Report

■ VARIOUS MEDICAL NEWS REPORTS and sundry articles in the public news media concern the nation's medical affairs. All of the articles reveal the need for increasing medical care, advocating reduction of medical costs, and pointing out the influence of government in medicine. Several times I have talked and written about encroaching federalism in the practice of medicine. You may call it what you wish—bureaucracy, federalism, or socialism—the fact remains that the public's tax dollars are being placed in the field of medical care—medicare, medicaid, regional medical care programs, and state comprehensive health planning—just to mention a few areas. Furthermore, millions of tax-supported dollars are annually funneled into the University of Wisconsin Medical School and Marquette School of Medicine in the form of grants.

As citizens and as physicians we must use these new modalities of public funds which are present within our midst and shape them for the future of our profession and the public health. Yet, we must be cognizant of the fact that the real specter of bureaucracy is at hand as evidenced by the now infamous "Corson Report." This report was produced by an advisory committee of the Department of Health, Education and Welfare on the relationships of that organization with state health agencies. It was reported to the Secretary of HEW (at that time, Mr. Gardner) on Dec. 30, 1966. I have read this report in its entirety and I believe it is very socialistic and bureaucratic in nature. Like many reports of our government, something as vicious as this and yet something that can be implemented has been kept very quiet. In fact the entire report is no longer available for publication, and chapters one and two as well as the appendices have never been reproduced for public dissemination.

This report, however, basically emphasizes that one of the obstacles to better health is obsolete governmental structure in state and local units which makes advancement in the provision of health facilities difficult. It repeatedly reiterates that "an overly rigid medical care system inhibits new approaches to the provision of health practices (as organized around solo practitioners and individual hospitals)."

Much of the report complains about the diffusion of health facilities throughout the federal government. Actually there are 18 federal organizations apparently concerned with health care at the present time. Even in the Department of HEW there are six agencies engaged in the health field. The report further states that "lack of strong state health agencies is the weak link in the chain of compulsory health services to all people at all times."

Some of the conclusions of the advisory committee of HEW promote the idea that where the state is unable or unwilling to assist in providing health service in urban areas, the urban government may deal directly and freely with the federal government. In the area of comprehensive state health planning this report suggests that the authority for the approval or disapproval of such plans should rest with the regional directors of HEW, but it does give the proviso that the state government can appeal any adverse decisions to the Secretary of HEW! This obviously is complete, socialistic bureaucracy.

continued on next page

The third conclusion and recommendation of this committee goes on to say "that a community health plan (P.L. 89–749,, comprehensive state health planning) should provide a full range of *personal* health services for all people, and such environmental health services as are susceptible to solutions on a community wide basis. This plan should include: a system for coordinating and integrating health services, the optimum *geographic* distribution of facilities, the establishment of neighborhood services and comprehensive *health care centers,* the conduct of health educational programs and experimental projects, and the application of improved methods for *controlling medical costs.*" (Emphasis in italics supplied)

I am certain this third conclusion of the "Corson Report" reveals in essence why many physicians are alarmed. This report obviously is not law at the present time except as portions of it are implemented under P.L. 89–749. However, the entire "Corson Report" has 29 conclusions, many of them taking away the rights of the personal physician, abrogating existing laws in our various states, and promoting centralization of government.

We must always be on guard and ever concerned about the latest developments in these legislative fields which jeopardize our profession. It is only by eternal vigilance that we can hope to stem the rising tide of socialism.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison, Wisconsin 53701.

Interprofessional Code

An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

Guide to The Service Corporation Law

A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

Code of Necropsy Procedure

A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

Hearing Conservation Programs for Wisconsin Industries

Some recommended standards and principles for providing a hearing conservation program in industry.

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General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

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An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

Inspection of Medical Records

An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

Principles for Transporting the Ill and Injured

A guide for providing emergency transportation services, including model community and state ordinances.

School Vision Screening Program

An outline to facilitate the development of a program to detect significant visual defects among school children.

First Aid Chart

Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959

Relating to fee splitting between physicians and others.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

MARCH 1968
Vol. 67 No. 3

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Relentless Futility

■ UNDETERRED BY THE ALMOST universal dismay of his former colleagues, Dr. Andrew C. Ivy, once the glory of the University of Illinois Medical School, continues his quixotic career at full tilt. After a dubious association with the brothers Durovic, which landed him in court in defense of Krebiozen, Doctor Ivy is now cozying up to those inveterate promoters of questionable cancer cures, the International Association of Cancer Victims and Friends. And to top things off, Doctor Ivy permits himself to be linked with Professor Revilo P. Oliver of the University of Illinois' classic department.

Doctor Ivy, it will be recalled with sadness, spent an illustrious lifetime devoted to medical science. The result of his research was substantial. As a teacher and a scholar he contributed much to advance the frontiers of medicine. Late in life, however, he erratically undertook the support of a cancer "cure" called Krebiozen. Although the circumstances of the discovery of this substance and its subsequent promotion by a pair of questionable characters ran contrary to all the standards he himself had previously espoused, Doctor Ivy sacrificed his position at the University of Illinois and his standing in the medical world in order to back Krebiozen. It was identified as creatin and its efficacy in cancer disproved, but Doctor Ivy was acquitted of a fraud charge. Currently he seems to be promoting another miracle substance, called "carcalon," which he claims is the only non-toxic chemotherapeutic cancer suppressive in existence. "Carcalon" was produced and tested in his own laboratory, and what its relation is to Krebiozen is anybody's guess.

Prof. Revilo P. Oliver is distinguished by more than a palindromic name. It was he who made the newspapers in 1964 with expressions of satisfaction at the assassination of President Kennedy. He claimed to have some secret knowledge of the reason for the murder, but when he was questioned by the Warren Commission it became apparent that he knew nothing. A big wheel in the high councils of the John Birch Society, he was recently dumped for unknown reasons. He is known as a rabid member of the radical right, given to intemperate utterances frequently couched in quasi-medical terminology. Although he is an embarrassment to respectable classicists everywhere, Oliver has managed to hang on to his job in the classics depart-

ment of the University of Illinois—truly an extreme example of academic tolerance.

Last February Doctor Ivy celebrated his 75th birthday. To honor him the Ivy Cancer Research Foundation, which seems to be an organization formed to support him, sponsored a birthday dinner. Modestly entitled "Salute to Genius" the affair featured Prof. Revilo Oliver as master of ceremonies and the accolades of some of the denizens of the dark alleys of Krebiozen, many of whom should know better. The event served as an occasion for the solicitation of contributions from misguided persons throughout the United States who believed that they were both honoring a great scientist and advancing the search of a cure for cancer.

It is depressing to contemplate what a brilliant occasion might have been made of Doctor Ivy's 75th birthday had he not abandoned the standards he stood for until a few years ago. It is also painful to consider the futility of the hopes of the people who sent money to the Ivy Cancer Research Foundation in the belief they were contributing to legitimate research.

Now that Doctor Ivy and Professor Oliver have found themselves to be birds of the same feather, it is to be hoped that they will together be recognized more readily for the pompous inanity they both represent—one anti-scientific and the other anti-social. Those who wish to contribute to worthwhile causes may consider the quality of these two persons and send their donations to legitimate research enterprises instead.—DNG

Postal Abuse

RESIDENTS OF AN undetermined number of cities and towns in the Middle West recently received a publication that identified itself as "Published in the Interest of Public Health by Spears Free Clinic and Hospital for Poor Children Inc., Denver, Colo." A professionally produced job, it brought news about the folks who had gone to Spears Hospital suffering not only from such prosaic maladies as angina pectoris, whiplash injury, asthma and epilepsy, but also from multiple eruptive hemangiomas, spastic blephora, toxemia, and a large variety of vague illness such as liver and gallbladder troubles which the patient described as resulting from "all the dope I took." They all emerged from Spears hospital, after very short stays, restored to the blessings of health and youthful vigor.

Oddly enough, some of the patients were so delighted with the outcome of their visit to Spears, they returned year after year, apparently just to say hello to the kindly practitioners who produced the miracle cures.

Spears Free Clinic and Hospital for Poor Children, Inc., is a chiropractic institution. It proclaims the doctrine, according to this mailer, that only nature cures and the doctor of chiropractic "assists nature by adjusting segments of the spine to correct vertebral distortions." In fact, the "*Spears Sanigram,*" as the publication is called, even shows a chart of the human body indicating just where the vertebrae are located affecting each section of the body. At the same time, it modestly admits that "no doctor can guarantee to cure any disease . . . we guarantee that we will do everything in our power to alleviate the suffering of all our patients and that we will do our utmost to restore them to normal health."

Left unsaid, of course, is why Old Mother Nature should require even chiropractors to aid her in her abundant curative powers so readily available to a suffering mankind.

A rapid perusal of the Spears publication suggests a number of features that must have piqued the curiosity of even the most naive. One might wonder, for example, why so many patients of the Free Clinic and Hospital for Poor Children turned out to be middle-aged folks and old-timers. One might also wonder how it happened that an institution dedicated to public health managed to have so many pictures of smiling patients standing around shaking hands with the "doctors." One might wonder why an institution that calls itself a hospital should find it necessary, in this day and age, to advertise for more patients.

It is easy for medical personnel and knowledgeable laymen to be derisive of the pathetic attempts of members of the chiropractic cult to delude the ignorant and the impatient sufferer. We know how easy it is for con-men to take advantage of miracle-seekers and those who refuse to face the facts of life. But we really have no right to laugh. The continuing existence of the chiropractic cult, despite the well-publicized prog-

ress of modern medicine, is a serious indictment of the medical profession. For as long as a single chiropractic cultist remains to attempt a cure of epilepsy, for example, by spinal manipulation or by high colonics, we have failed to educate our communities about the realities of health care.

But our own self-indictment is nothing compared to the indictment that should be made of the Post Office that permits manifestly deceptive and misleading literature of the character of the "Spears Sanigram" to be distributed indiscriminately at third class matter rates—to the potential damage of the community.

One can also wonder why the federal watch-dog agencies, such as the Food and Drug Administration and the Federal Trade Commission, which are so sensitive about the consumers' dollars and the possible deceptive effects of medical advertising claims, are so indifferent when it comes to the misleading statements of the chiropractic cultists.

It is long past the time when the government should have gotten into the matter of policing chiropractic claims; a concerned medical profession should urge it to do so —and soon.—DNG

LETTERS

CARCINOMA OF THE LIP—TREATMENT BY SURGERY OR RADIATION?

To the EDITOR:

The article on carcinoma of the lip in the October issue of the *Wisconsin Medical Journal* (page 515) contains some very misleading implications regarding cancer therapy.

In mentioning radiation therapy of lip cancer, the author states that: "Control of the primary lesion was obtained in 73 per cent of cases." The reference he gives for this statement is footnoted as "4. Lampe, 1959." It is surprising to see such a reference as this in a reputable medical journal.

I have no idea who "Lampe, 1959," is. But *THE Dr. Lampe*, whose name is respected by radiation therapists the world over, tells me he has no recollection of ever having made such a statement! (Personal oral communication on November 29th, 1967.) Dr. Lampe informs me that he has published some data on very extensive carcinoma of the lip, involving the entire lower lip (and more) in which control of the primary lesion was achieved in perhaps only 70 to 80 per cent of cases. He states, however, that when lip lesions involving less than one-half of the lower lip are treated by irradiation, recurrence at the primary site is extremely rare.

This has been the experience of practically every competent radiation therapist. In the past 15 years, some 39 patients have been treated in our hospital for carcinoma of the lip. I do not claim to know exactly where every one of these patients is now, and I am sure that some of them are no longer among the living. But I can honestly say that I have not seen, or heard of, a recurrence at the primary site in a single one of these patients.

Almost every radiation therapist has had the experience that small lip cancers are often excised by surgeons, and about 10 to 15 per cent of these eventually come to a radiologist with recurrences which are very hard to treat because of the prior surgical intervention. Large lip carcinomas, on the other hand, are usually referred to radiologists in the first place. Surgeons often express amazement that radiologists are able to control most of these large primary lesions, yet they seem not to realize that radiologists do even better with small lip cancers.

These facts can be confirmed by simple reference to the standard works on modern radiotherapy. For example, Dr. Walter T. Murphy in *Radiation Therapy*, 2nd Edition, 1967, on page 169, points out: "generally, with the techniques used today, the 5 year control rate resulting from irradiation of the primary lesion should average over 90 per cent, except when some type of definitive treatment has already been given and failed." Observe that Dr. Murphy is referring to all lip carcinomas, not just small ones!

So far as cosmetic results are concerned, note that all of the illustrated cases in the October Journal article are *small* cancers. The surgical cosmetic results are disproportionately poor in view of the small size of these lesions when compared with fractionated irradiation therapy for lip lesions of similar size. Every case operated upon shows a surgical scar, and many of the patients are disfigured. Lesions of similar size treated properly with fractionated irridation leave no such obvious defect.

I think it is appropriate that our state journal set the record straight for the guidance of physicians in our state in the care of their patients who have primary carcinoma of the lip.

1. Any carcinoma of the lip should be referred to a competent radiation therapist. Biopsy should involve removal of a very small piece of tissue, so as to avoid any permanent defect.
2. If the tumor occupies less than one-half of the lower lip, and has had no prior treatment, control of the *primary* tumor will be accomplished by radiation therapy in more than 98 per cent of the cases, in my opinion.

3. Cosmetic results are always better with radiation. Good radiation therapy destroys tumor cells selectively and only slightly injures normal tissues. Surgery requires wide excision with sacrifice of huge amounts of normal tissue, and mutilation of the patient is inevitable under these circumstances.
4. Metastases in the neck should be dealt with surgically in most cases.
5. Rare recurrences of primary tumor may be subjected to surgical correction. Chemosurgery is especially useful in this connection.

HOWARD MAUTHE, M.D.
Fond du Lac

To the EDITOR:

I would like to thank the editors of the *Wisconsin Medical Journal* for allowing me to give a spirited reply to the letter written by Doctor Mauthe regarding my article on "Lower Lip Reconstruction for Carcinoma." (October 1967 issue)

Relative to the treatment of carcinoma of the lower lip, and its eventual reconstruction, this has certainly been a field which has been treated by both radiation therapists and surgeons. I first want to mention that there is a definite place for radiation therapy in the treatment of malignancies, but certainly in lesions of the lower lip in which the surgeons have excellent exposure, surgical intervention is the best means for cure. There is no question that surgical treatment of carcinoma of the lower lip controls the early and non-clinically apparent lesions in addition to quickly removing the extensive bulky lesions of the lip. It makes available a specimen for thorough study as to adequacy of treatment. The wounds usually heal in a week and most of the patients treated are out-patients and the procedure is done with the region under local anesthesia. Approximately one-half of the lip can be excised, and closed without producing much of a deformity. If more of the lip has to be sacrificed, in more extensive lesions, replacement with lip tissue from the upper lip or neighboring tissue can be performed with very minor cosmetic deformity as seen in my article.

In treating lesions of the lower lip by radiation therapy, one never really knows whether or not the entire lesions have been eradicated. Furthermore, radiation therapy often times causes considerable scarring, thickness to the lip, and radio dermatitis to the skin as manifested by atrophic skin and altered pigmentation. Although tumor cells are more susceptible to radiation therapy, many normal cells are also injured and destroyed by radiation effects. Surgery does require a good margin of excision but never sacrificing of *huge* amounts of normal tissue. The lower lip which is involved by diffuse leukoplakia often contains multicentric carcinoma. The differentiation being only microscopic sections. The lip shave procedure allows for accurate diagnosis and treatment of the offending lesions. Furthermore, in the reconstruction of the lower lip following larger re-sections, one must take adjacent skin or skin from the neck which has the same texture, tone, and color match and thusly one accomplishes a very fine reconstruction.

I do not believe that a patient with a suspicious lesion of the lower lip which has failed to heal, should be referred first to a radiation therapist. I am fully aware of the great accomplishments of Doctor Lampe and I believe wholeheartedly in his wonderful accomplishments. Relative to the incompleteness of the bibliography, this was a typographical error and I am sorry for the omission; however, the article that I referred to written by Doctor Lampe in 1959 in the *Plastic & Reconstructive Journal* is "The Place of Radiation Therapy and Treatment of Carcinoma of the Lower Lip," volume 24, July 1959, pp. 34–44. Lesions treated in this article were considerably advanced by measuring 3.5 cm. or greater in diameter. Similar lesions this size were treated very well by surgery as was illustrated.

I do not wish the impression that I am adamant against radiation therapists for they are my very close friends and often are called upon for help in combination or solely in the treatment of malignancies. I was sure that I would get a response from a radiation therapist regarding treatment of carcinoma of the lower lip, and I am pleased, for this allows the State Medical Journal to be more interesting. Needless to say, this is a gray zone in which various specialties treat these specific lesions. This has been a point of argument through the years and I presume will forever be present.

I can only summarize that in my hands the surgical excision and reconstruction of carcinoma of the lower lip works extremely well, and I gather that Doctor Mauthe's results with radiation therapy have been equally as effective.

GEORGE J. KORKOS, M.D.
Milwaukee

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

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CARDIOPULMONARY RESUSCITATION REPORT

A complete report on the Conference on Cardiopulmonary Resuscitation is now available from the American Heart Association.

To obtain a copy of "Cardiopulmonary Resuscitation—Conference Proceedings" send your request together with $5.75 ($4.50 for Heart Association members) to the American Heart Association, 44 East 23rd St., New York, 10010.

THE MEDICAL STUDENT FORUM

Devoted to the expressions of the medical students at the University of Wisconsin and Marquette medical schools through association with the Student American Medical Association. A feature originated by the State Medical Society of Wisconsin to stimulate closer relationships with the physicians of tomorrow. This space is offered monthly to both schools on an alternating basis, with copy deadline the first of the month preceding the month of publication. Statements and opinions contained herein are those of the students.

MARCH 1968

THERE IS A GROWING discontent among many medical students today. One of the results of this movement at the University of Wisconsin Medical School has been the formation of a new organization called the *Madison Student Health Organization*. To explain the purpose of this new group, I would first like to give a subjective account of the thinking of many medical students today.

NEW STUDENT HEALTH GROUP

Many of the same old questions about the goals of medicine and the relationship between the medical profession and society are being asked by medical students today. But there is a growing tendency to challenge much of the old dogma, to question the basic premises upon which the dogma is enmeshed. Let me be more specific: in the doctor–patient relationship, who comes first? Idealistically, we students think that the welfare of the patient should be the primary consideration, but we know that frequently this is not the case.

Many factors interpose themselves between the doctor and the patient. Money, of course, is a good example. We have not forgotten the ugly scenes we have witnessed where medical care was not given or was severely delayed because it was feared that the patient might not be able to pay. It is a very difficult thing for students to see that education is considered important enough to be a legal right of every citizen of this country, while something like satisfactory health which is much more basic and important, is still considered a luxury, dispensed to the elect customers of a health broker. Surely there is a discrepancy here, and we as future members of the profession cannot accept it.

NEW APPROACHES NEEDED

We students think that the leadership of the medical profession should be using its intelligence and position to explore new approaches to some of our country's health problems, instead of using the wealth and prestige of the profession to stifle new ideas. Many students were quite ashamed of the massive effort of organized medicine to kill the Medicare bill *without offering practical solutions to the obvious problem*. We are still more ashamed of the physicians who are increasing their fees excessively now to take advantage of the bill.

Of course the most discouraging thing of all is to talk with doctors about these grievances, and to be told we are "suffering from the idealism of youth" and "you will soon outgrow your dissatisfaction and come to see the advantages of reactionary thought." Many of us can't accept this. For that reason we have joined together to form the Madison Student Health Organization. We realize that the delivery of medical care is more than a medical problem: it is a community problem requiring a community effort toward solution. It is not unrelated to the other very pressing problems of racism, poverty, and the war in Vietnam.

PHYSICIANS ONLY, NOT ENOUGH

We are a multidisciplinary group of medical and nursing students, medical technologists, physical therapists, occupational therapists, sociologists, economists, and social workers. We seek to educate ourselves in the expanding role of the medical profession, and we feel that a multidisciplinary approach will allow us to pool our knowledge and at the same time reduce the separation between the various branches of medicine.

We shall sponsor lectures and group discussions with various people active in the health sciences, from the medical profession, the social sciences, and the government. We hope that by doing this we will be able to bolster our idealism with solid facts so that we can convince our classmates and associates that some of the dogma that the medical profession has long been saddled with is not only unpalatable but unrealistic.

Finally, we have found that the best way to educate ourselves is to descend from the ivory tower and to get our hands dirty working.

HELP TO MIGRANTS A START

In the summer of 1967, 18 medical students and six faculty members donated some time to trying to improve the health care of some of the migrant workers in Wisconsin. It was a start but certainly not good enough, and we have been working hard (and against much resistance) to improve our project for the summer of 1968. Twenty students have indicated that they would like to work either full or part-time, and the response from the faculty has been encouraging.

As an illustration of how our work projects fit into the educational purpose of our organization, let me quote from the report of last summer's activities:

> "In addition to helping achieve a minimum standard of medical care, we would like to explore the possibilities of giving unusually good care to the migrants, as an example of medical tasks which apply to millions of other underprivileged people. The American migrant worker is a prototype group which is undereducated with respect to health, insulated by language from the culture which surrounds him, unable to afford major expenses, and kept by his tradition and work from some of the beneficial habits of hygiene and nutrition. If the health of this group can be improved during a sojourn in Wisconsin, it will be a model for many similar situations throughout the world."

SECTION OPHTHALMOLOGY

MARCH 1968 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

GRADUATE AND POSTGRADUATE EDUCATION IN OPHTHALMOLOGY AT MARQUETTE

THE OPHTHALMOLOGY Department at Marquette School of Medicine has expanded its residency program to provide training for 19 physicians at its four teaching hospitals in Milwaukee. Program changes have included the establishment of subspecialty clinics in the areas of external diseases of the eye, muscle problems, glaucoma, neuro-ophthalmology, refraction, ocular pathology, retinal disease, and plastic surgery.

The present full-time staff of this department has five faculty members who are responsible for special areas of teaching, research, and patient care: R. O. Schultz, M.D., Associate Professor and Chairman, infectious and external diseases of the eye; E. B. Suson, M.D., Assistant Professor, glaucoma service; O. A. Wiegmann, M.D., Assistant Professor, pediatric ophthalmology; W. E. Gager, M.D., (beginning July 1, 1968), Assistant Professor, neuro-ophthalmology; and Jack C. Copeland, Research Associate, refraction and retinoscopy. This faculty structure is augmented by two full-time Ph.D. members in the research division: H. F. Edelhauser, Ph.D., corneal physiology; and Diane L. Van Horn, Ph.D., electron microscopy. In addition 20 volunteer and part-time faculty members provide supervision for training and patient care in other subspecialty areas and in the general eye clinics of the teaching hospitals.

The Ophthalmology Department considers one of its important functions to be the presentation of regular postgraduate conferences for the practicing physician. These include: monthly clinical conferences on the second Friday of each month where patients of faculty members are presented for discussion; monthly seminars on a topic of current interest in ophthalmology given by the resident physicians in training; and a schedule of visiting professors and guest lecturers offered in conjunction with the regular meetings of the Milwaukee Ophthalmological Society.

For the present academic year guest lecturers and visiting professors are: Alson E. Braley, M.D., November 28 and 29, 1967; David Shoch, M.D., January 30, 1968; Miles Galin, M.D., February 27, 1968; and J. Lawton Smith, M.D., May 15 and 16, 1968. Other departmental functions which are available to staff members include Journal Club meetings and a joint conference with Neurology held on alternate Tuesdays of each month.

The Marquette Ophthalmology Department also maintains referral clinics and special laboratories for services to the referred patient. As one example the Glaucoma Clinic performs particular tests such as tonography, quantitative field studies, gonioscopy, and serial fundus photography to aid in clinical consultation. Similar diagnostic aids are provided for muscle cases and pediatric eye problems; fluorescent angiography and a photo-coagulation unit are available for retinal disease; and an eye pathology laboratory receives and reports on all biopsy and enucleation specimens. Consultation for infectious and external eye problems has been aided in the past year by the establishment of a major clinical and laboratory research program in diseases and surgery of the cornea. This laboratory is also utilizing techniques to preserve corneal tissue for full-thickness transplants in cooperation with the Wisconsin Lions Eye Bank.—R. O. SCHULTZ, M.D.

WISCONSIN–UPPER MICHIGAN SOCIETY OF O–O

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology met at Bailey's Harbor Sept. 16–17, 1967.

The following officers were elected: president, Dr. Robert C. Randolph of Manitowoc; vice-president, Dr. Frank J. Cerny of Fond du Lac; and secretary–treasurer, Dr. George L. McCormick of Waukesha.

A spring meeting will be held May 25–26 in Manitowoc. There will be clinical sessions at Holy Family Hospital and a dinner at Branch River Country Club. Speakers will be announced later.

SERIAL FLUORESCEIN ANGIOGRAPHY

The Lutheran Hospital of Milwaukee is now equipped to do serial fluorescein angiography of the retina. Ophthalmologists desiring to refer patients for this examination should contact the ophthalmology resident at the Lutheran Hospital, 2200 West Kilbourn Ave., Milwaukee, Wis.; tel. 342–8500.

DATES TO REMEMBER

APR. 23: Scientific program, Milwaukee Ophthalmic Society, University Club, Milwaukee.

MAY 16: Annual meeting and scientific program, Section on Ophthalmology, in conjunction with State Medical Society annual meeting, Hotel Sheraton Schroeder, Milwaukee. (See complete Ophthalmology program starting at page 194 of this issue.)

The Wisconsin Regional Medical Program OPERATIONAL PROJECTS

By JOHN S. HIRSCHBOECK, M.D., Milwaukee, Wisconsin

■ MORE THAN A YEAR has passed since The Wisconsin Regional Medical Program, Inc., assisted by a grant from the Division of Regional Medical Programs of the National Institutes of Health, became a health-planning agency under Public Law 89–239. On Sept. 1, 1967, The Wisconsin Regional Medical Program was given operational status and received funds for the support of five operational projects in addition to funds for planning. The total grant for the period Sept. 1, 1967, to Aug. 31, 1968, is $319,458 for direct costs.

TABLE 1—*Study Groups and Committees of the Planning Committee of The Wisconsin Regional Medical Program, Inc.*

Cancer Study Group	Robert O. Johnson, M. D., Associate Professor of Surgery at the University of Wisconsin, Chairman
Heart Study Group	Dean A. Emanuel, M. D., of the Marshfield Clinic, Chairman
Stroke Study Group	Philip T. White, M. D., Professor of Neurology at Marquette School of Medicine, Inc., Chairman
Resource Study Group	Mr. Donald C. Slichter, Chairman of the Governor's Task Force on Medical Education, Chairman
Measurement and Data Collection Committee	David H. Gustafson, Ph. D., of the Planning Staff of The Wisconsin Regional Medical Program, Inc., Chairman
Postgraduate Education Committee	Thomas C. Meyer, M. D., Assistant Dean for Postgraduate Education of the University of Wisconsin Medical School, Chairman
Nursing Advisory Committee	Mrs. Dorothy J. Hutchison, R. N., Nursing Specialist, Department of Nursing, University of Wisconsin Extension, Chairman

PLANNING ACTIVITY

The Planning Committee under the chairmanship of Gerald Nadler, Ph.D., Professor of Industrial Engineering at the University of Wisconsin, assisted by staff engineers and systems analysts, has developed a Model of Health-Care Activities for citizens of the Wisconsin region. The Model is built of thousands of possible components and is used by the staff and study groups of The Wisconsin Regional Medical Program to assist them in developing projects for the region. The Planning Committee is supported by a number of study groups and committees. These are listed in Table 1.

The Planning Committee and its Study Groups are in the process of evaluating 40 proposals which have been received from various individuals and health agencies in the region. Each Study Group is evaluating these proposals in terms of their potential value as Regional Medical Program projects. In addition, each Study Group is developing proposals of its own to implement comprehensive plans each has developed within the overall Model. It is anticipated that a number of these proposals will be incorporated into an application for an expanded operating program which will begin Sept. 1, 1968.

More than 100 people are involved in developing Regional Medical Program projects in the Study Groups and subcommittees of the Planning Committee.

THE NURSING COMMITTEE

The Nursing Committee was one of the first committees to be appointed. It acts as an advisory group to the staff and the Planning Committee regarding nursing problems. It is focusing its attention more directly on the problem of improving the supply of nurses for the region, and as such will sponsor programs designed to bring inactive nurses back to practice.

THE POSTGRADUATE EDUCATION COMMITTEE

The Postgraduate Education Committee is concerned with the development of a long-term program for expanded postgraduate education for the health professions in the Wisconsin region. Its overall plans call for the development of the following programs:

I. *Inter-regional level*
   A. Conferences related to Cancer, Heart Disease, Stroke, and allied diseases.
   B. Workshops
   C. Visiting professorships
   D. Development of Dial-Access Tapes

Doctor Hirschboeck is Regional Program Coordinator for The Wisconsin Regional Medical Program. This semi-annual report is presented with support from The WRMP.

II. *Intra-regional level*

A. *General*

1. Use of communications technology within the region.
   a. Television
      1. Broadcast
      2. Closed Circuit
      3. Slow-scan
   b. Radio
   c. Telephone
   d. Single Concept films
2. Hospital affiliation with Medical Schools (M.D. and allied Health levels)
3. Phonograph records on medical advances

B. *Community level*

1. Visiting professorships
2. Circuit courses
3. Utilization review
4. Patient care research
5. In-service training, with reimbursement, at medical schools or selected clinics.

C. *Individual Physician Level*

1. Dial Access Tape Recording Library
2. Individual physician profile
3. Programmed instruction
   a. Book
   b. Computer assisted
4. Tapes adaptable for use in cars

The committee would like to encourage the development of programs along these lines through the use of existing agencies and the introduction or support of new programs in continuing education of all those engaged in the health sciences.

THE REGIONAL ADVISORY COMMITTEE

Public Law 89–239 under which the Regional Medical Programs operate requires the appointment of a Regional Advisory Group which has the authority to pass on all applications for grants which are submitted to the Division of Regional Medical Programs of the National Institutes of Health. The Regional Advisory Committee of The Wisconsin Regional Medical Program is broadly representative geographically of professional and community interests in Wisconsin. The Committee meets regularly every three months. In May 1967 an all-day conference was held at Wingspread, the Johnson Foundation Conference Center near Racine. This was followed in September by an all-day Workshop which was held in the Employers Insurance of Wausau headquarters at Wausau. The subject of the Workshop was "Opportunities for Collaboration." In December the Advisory Committee met at the Northwestern Mutual Life Insurance headquarters in Milwaukee. At that time it adopted a policy statement regarding cooperative arrangements. This statement was developed from the comments and discussion which occurred at the September Workshop Conference in Wausau.

THE PROFESSIONAL STAFF

The professional staff of The Wisconsin Regional Medical Program is headed by John S. Hirschboeck, M.D., as Regional Program Coordinator. He is assisted on a half-time basis by Doctors Robert O. Johnson and J. D. Kabler of the faculty of the University of Wisconsin Medical School, by Dr. Marion Mykytew on a full-time basis at the Marquette School of Medicine, and Mr. James H. Sullivan who is attached to the headquarters of The Wisconsin Regional Medical Program which is located at 110 East Wisconsin Avenue in Milwaukee. In addition to the planning staff, Mr. Roy Ragatz is Coordinator for Postgraduate Education Programs, Miss Martha Jenny is Nursing Coordinator, and the work of the Planning Committee is carried out by a full-time staff of three Planning Associates. The operational projects now under way in The Wisconsin Regional Medical Program are as follows:

- A Study Program for Uterine Cancer Therapy and Evaluation.
- A Demonstration Program for Pulmonary Thromboembolism.
- Dial Access Information Service for Physicians.
- Dial Access Information Service for Nurses.
- Single Concept Films in Heart Disease, Cancer, and Stroke.

The first project is concerned with the development of a cooperative arrangement between Milwaukee County Hospital and University Hospitals in Madison, specifically between the Departments of Gynecology and Obstetrics and Radiation Therapy in these institutions. The purpose of this project is to develop a readily available dosimetry service for radiation therapy of uterine cancer.

As the first step in making these special techniques and experience more widely available in this region, communications between the two centers have been established which permit direct exchange of standardized treatment data. A series of joint conferences has been started which will allow personnel in both centers to pool their knowledge and experience.

Computer capabilities, formerly available only at the University of Wisconsin Medical Center, are now being used to provide a detailed picture of radiation dosage for every patient treated for uterine cancer in both centers. In this system x-ray pictures are made of the radium in place in each patient. The position of each radium capsule is determined and this information is relayed to the computer center. A picture or plot of the amount of radiation received by the tissues at various points around this radium applicator is automatically printed out by the computer in as little as two to three minutes, a process that would have taken many days to do by hand calculators. These plots allow both centers to

compare the results of their therapy and provide a common language for detailed description of each patient's treatment. This information will make possible evaluation of the different methods used in the two centers, as the ultimate results of treatment (in terms of cure) become known. Under the terms of this regional program the two centers are planning the expansion of this common language to make possible the pooling of all clinical information concerning these patients. The patient's history of disease, the results of the examination by the physician, and the details of later complications or recovery will be recorded. To do this, preliminary programs have already been developed which allow the use of a small computer, the LINC, in questioning patients and their physicians, thus directly assuring that nearly identical information will be gathered in both medical centers. Pooling of such data will allow a much larger group of such patients to be studied than could be accumulated by any individual center and important observations not otherwise possible may be made with regard to the diseases under treatment and study.

The development of this cooperative program will provide a training ground for personnel capable of establishing other cooperative centers in the region. The need and location of future centers will be defined by planning studies now in progress under the auspices of the regional program. Establishment of such centers in other areas would assure physicians and patients in these areas increasing availability of new techniques in the management of uterine cancer and perhaps serve as a model for similar efforts in the management of other diseases.

The second project is concerned with the development of a program to deal more effectively with pulmonary thromboembolism. Some physicians have asked why the Regional Medical Program has selected this particular disease. There are, in our opinion, three important reasons for this. First, pulmonary thromboembolism is a common disease. Reports indicate that pulmonary thromboembolism is present in 64% of autopsied cases. Deaths from pulmonary embolism and infarction in Wisconsin exceed the national rates. For example, in 1964 the mortality rate in the United States as a whole was 2.79 per 100,000 population, whereas in Wisconsin it was 4.28 per 100,000 population. Second, a group of physicians at the Marshfield Clinic are engaged in important developmental research in the rapid diagnosis and treatment of this condition. They are collaborators in the national program to evaluate urokinase as a thrombolytic agent. Third, the subject lends itself well to developing cooperative arrangements between the Marshfield Clinic and other hospitals in the Central Wisconsin region. The goals of the proposed program are as follows:

1. To determine the extent to which pulmonary thromboembolism is a factor in morbidity and mortality in the Wisconsin region.
2. To devise a regional plan for introducing methods to diagnose pulmonary thromboembolism quickly in the hospitals throughout the region.
3. To establish centers in the region where patients in acute danger of a primary or recurring pulmonary thromboembolism can be managed to mitigate the effects of the embolism and prevent recurrence.
4. To devise a plan for transporting patients rapidly from sparsely populated areas to these centers.
5. To establish pilot and demonstration programs for developing and improving the means for rapid diagnosis and treatment of patients with thromboembolic disease.

The pulmonary thromboembolism project will eventually involve the collaborative efforts of the two medical schools in addition to the medical staffs of many of the hospitals in the region.

The remaining operational projects which are in the field of postgraduate education for the health professions are extensions of programs which already had been initiated on a pilot basis by the University of Wisconsin Extension. These projects are under the direction of Dr. Thomas C. Meyer, Assistant Dean for Continuing Education at the University of Wisconsin Medical School, and Mr. Ragatz. The Dial Access Information Service will be expanded to include a large number of informational tapes prepared by physicians in Madison, Milwaukee, and other cities in the State on topics in heart disease, cancer, stroke, and related diseases. Three tape libraries are being established: one in Madison, one in Milwaukee, and a third in Madison for physicians throughout the region who reside outside of the two cities. Access to the library will be through toll-free telephone. The service will be available 24 hours a day. Considerable publicity has been given to this program.

A Dial Access Library for Nurses is also being developed.

A number of motion picture films are being developed by the faculties of the two medical schools for viewing in automatic projectors which will be stationed in strategic places in the hospitals of the region.

CONCLUSION

I wish to emphasize that the Regional Medical Programs are being looked upon with great interest and enthusiasm by important groups within the medical profession. The American Heart Association, at its recent meeting in San Francisco, devoted a very substantial part of the program to a review of the opportunities in Public Law 89–239. This is a medical program. It is designed to assist physicians in their professional activities. The program's emphasis is on the development of cooperative arrangements between physicians and groups of physicians, and between hospitals, medical schools, and other health-related institutions to improve the availability of resources for practicing physicians.

Public Law 89–239 expires on June 30, 1969. Congress has asked the Surgeon General of the Public Health Service to make recommendations regarding continuation of the program. These recommendations have been incorporated in a Report to the President and Congress which was released by the President in November 1967. The Surgeon General's Report carries the recommendation that the Regional Medical Program legislation be continued for five years following its expiration, and that appropriations in the neighborhood of $500,000,000 a year be made to continue the operational phases of the program. If this money is distributed throughout the United States on a population basis, it can be estimated that The Wisconsin Regional Medical Program will receive at least $11,000,000 a year for Regional Medical Program projects. Since this money will be available principally to assist the medical profession in improving its capability to deliver health-care services of high quality, it is essential that the medical profession, the health professions, hospitals, medical schools, and other health agencies collaborate fully in developing worthwhile projects to carry out these goals.

The Report of the Surgeon General to the President and Congress summarizes the goals of Regional Medical Programs in the following words:

"When the Regional Medical Programs are fully developed across the nation, they will help to assure every individual, wherever he lives, that:

"His physician has readily available the knowledge, skills and technical support that permit early diagnosis of these diseases and prompt initiation and appropriate follow through for the most effective known preventive or curative action.

"His community hospital is equipped and staffed to provide the full range of services his condition requires, or is part of a system which makes this range of services available to him.

"In short, every person whose life and well-being may be in jeopardy from one of these diseases should have the full strength of modern medical science available to him through the cooperative efforts of the medical and related resources of the region in which he lives. These are the goals to which Regional Medical Programs are dedicated."

WISCONSIN'S HEALTH

by E. H. JORRIS, M.D., State Health Officer

STATE BACKS NEW TUBERCULOSIS PROGRAM

Until a few years ago the only available means of curbing the spread of tuberculosis was isolation of the person with active disease. Often this was done after many contacts had been infected by the diseased person prior to medical care. The drugs used to treat tuberculosis, principally isoniazid, are equally effective in preventing development of clinical disease.

Official and voluntary health agencies developed programs to provide identification of infected individuals and to provide facilities to obtain the necessary medical evaluation and treatment. Identification is made primarily through large scale skin test programs. Possible contacts are then sought and checked for source of infection. An interagency committee of the Division of Health and the Wisconsin Anti-Tuberculosis Association, after careful study of the literature and Wisconsin resources, developed a priority list for action. The recommendations are similar to the recommendations of the Public Health Service and National Tuberculosis Association.

Priorities for preventive treatment of adults with tuberculin test reactions of 10 mm or more are first,

persons who have had clinical tuberculosis and were treated without the use of drugs, and second, positive tuberculin test reactors with an abnormal chest x-ray.

Persons with a positive skin test have high priority if they suffer from a complicating illness such as diabetes and silicosis which lowers their resistance to infection or if they live under adverse socio–economic conditions or in overcrowded quarters.

Those persons recently infected, as evidenced by a change in the tuberculin skin test to positive, should receive chemoprophylaxis.

Infected children up to four years of age should be treated as active cases. Puberty is a period of increased danger and high priority for chemoprophylaxis. The need for chemoprophylaxis for those between the age of four and puberty should be evaluated by the attending physician.

* * *

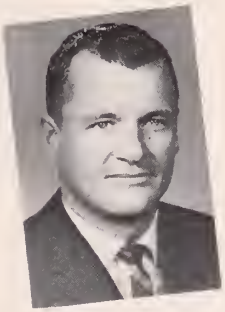
PAMPHLET: PLASTIC SURGERY

A new pamphlet developed by the American Academy of Facial Plastic and Reconstructive Surgery is now available for use in physicians' offices and reception rooms where it can be read by patients. The pamphlet corrects several false impressions and answers many of the more common questions asked about plastic surgery. Folders in quantity are available at cost: $3.00 per 100. Contact: Jack R. Anderson, M.D., Secretary, 322 California Company Bldg., 1111 Tulane Ave., New Orleans, La. 70112.

127th Annual Meeting

STATE MEDICAL SOCIETY of WISCONSIN

MAY 14–16, 1968
MILWAUKEE



THOMAS V. GEPPERT, M.D.
General Chairman

The Commission on Scientific Medicine is pleased to invite you to attend the 1968 Annual Meeting of the State Medical Society of Wisconsin, in Milwaukee, May 14 through 16. A wide variety of subjects is offered for your scientific exploration. The meeting this year is endeavoring to bring pertinent, updated information to the membership so that meaningful, take-home, practical benefits will inure for you in your practice.

All physicians are invited to attend the 1968 Annual Meeting which emphasizes a variety of specialty subjects. On the following pages you will find a complete schedule of the scientific program of your choice and we urge you to visit the technical and scientific exhibits. A printed program will be mailed to member physicians in mid-April. We hope to see you in Milwaukee May 14–16.

Sincerely,

Thomas V. Geppert, MD

THOMAS V. GEPPERT, M.D.
Chairman, Commission on Scientific Medicine

Timetable

NOTE: S–S: Sheraton–Schroeder Hotel

SUNDAY, MAY 12

Noon
12:00 Council Luncheon: East Room (5th Fl. S–S)

p.m.
2:00 Council Meeting: English Room (5th Fl. S–S)
6:00 Fifty-Year Club Dinner: Councilors, Officers, Wives and Special Guests (New Members of Fifty-Year Club and wives): East Room (5th Fl. S–S)

MONDAY, MAY 13

a.m.
8:00 Installation of exhibits: Milwaukee Auditorium

Noon
12:00 Board of Directors Wisconsin Academy of General Practice Luncheon: English Room (5th Fl. S–S)

p.m.
2:00 Congress of Delegates, Wisconsin Academy of General Practice: East Room (5th Fl. S–S)
5:30 Auxiliary Board Meeting and Dinner: Loraine Room (S–S)
6:00 Buffet Supper for Delegates and Officers: East Room (5th Fl. S–S) and Registration for House of Delegates (5th Fl. Foyer S–S)
7:00 First Session, House of Delegates: Ballroom (5th Fl. S–S)

TUESDAY, MAY 14

a.m.
7:30 Catholic Physicians Guild Breakfast: East Room (S–S)
8:00 Registration and Opening of Exhibits: Milwaukee Auditorium
9:00 Auxiliary: Registration and Continental Breakfast: Loraine Room (S–S)
9:00 Reference Committees: Resolutions and Amendments: Ballroom (5th Fl. S–S); Reports of Officers: Parlor G (4th Fl. S–S); Reports of Standing Committees: Parlor H (4th Fl. S–S); and Finances: Parlor I (4th Fl. S–S)
9:30 Auxiliary Business Meeting: Loraine Room (S–S)
9:30 Scientific Programs: "Osteoporosis": Milwaukee Auditorium

Noon
12:00 Clinic Managers Luncheon: Pfister Hotel

p.m.
12:30 Auxiliary Luncheon: Wisconsin Club
12:30 Scientific Luncheons: 4th and 5th Floors (S–S)
2:00 Scientific Programs: Milwaukee Auditorium
Internal Medicine
Obstetrics and Gynecology
Radiology
3:00 Nominating Committee: Room 504 (5th Fl. S–S)
6:00 Marquette Alumni Dinner: Milwaukee Athletic Club
6:30 Radiology Dinner (Members only): Milwaukee Yacht Club
7:30 Second Session, House of Delegates: Ballroom (5th Fl. S–S)

WEDNESDAY, MAY 15

a.m.
7:30 PACE Breakfast: East Room (S–S)
8:30 Registration and Exhibits: Milwaukee Auditorium
9:00 Auxiliary, Registration and Continental Breakfast: Loraine Room (S–S)
9:00 Third Session, House of Delegates: Ballroom (5th Fl. S–S)
9:30 Auxiliary Business Meeting: Loraine Room (S–S)
9:30 Scientific Programs: Milwaukee Auditorium "Use of Computers in Medicine"
10:30 Council Meeting: Club Rooms (3rd Fl. S–S)

p.m.
12:30 Council Luncheon: Club Rooms (3rd Fl. S–S)
12:30 Scientific Luncheons (4th and 5th Fls. S–S)
12:30 Auxiliary Luncheon: Empire Room (S–S)
2:00 Scientific Programs: Milwaukee Auditorium
Allergy
Dermatology
Neurology
Pediatrics
6:30 President's Reception (For those attending Dinner): East Room (5th Fl. S–S)
7:15 Annual Dinner: Ballroom (5th Fl. S–S)

THURSDAY, MAY 16

a.m.
8:00 Seminar on the Kidney (Pre-registered physicians only): Pere Marquette Room (5th Fl. S–S)
8:00 "Wet Clinic" Wisconsin Surgical Society: Veterans Administration Hospital, Wood
8:30 Registration and Exhibits: Milwaukee Auditorium
9:30 Scientific Programs: Milwaukee Auditorium and S–S
9:30 Scientific Programs: Milwaukee Auditorium and Auditorium
9:30 Ophthalmology Demonstrations and Exhibit: East Room (5th Fl. S–S)
10:00 Resident-Intern Program: Milwaukee Auditorium

Noon
12:00 Past Presidents Luncheon: Club Rooms (S–S)
12:30 Scientific Luncheons (4th and 5th Fls. S–S)
2:00 Scientific Programs: Milwaukee Auditorium
Anesthesiology
Surgery
2:00 Ophthalmology Scientific Program: East Room (5th Fl. S–S)
2:00 Otolaryngology Scientific Program and Business Meeting: Milwaukee Auditorium
6:00 Wisconsin Orthopaedic Society Dinner (Members only)
6:30 Ophthalmology Dinner: University Club
7:00 Wisconsin Surgical Society Dinner (Members only): Milwaukee Athletic Club

IMPORTANT INFORMATION

★ **REGISTRATION:** Pick up your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Fifth and Kilbaurn Street. The time Tuesday, 8:00 a.m.–4:30 p.m.; Wednesday, 8:30–4:00 p.m.; and Thursday, 8:30 a.m.–3:30 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Senior and junior medical students will be admitted an Wednesday and Thursday, May 15–16. Medical assistants and hospital persannel will be admitted on Thursday, May 16 *anly after 11:00 a.m.* Interns and residents will be admitted without registration fee, any time during meeting, *if certified by hospital.* Members of the Wisconsin State Dental Saciety and aut-of-state physicians who are members of their county and state medical societies will be admitted by membership cards.

★ **VA and M.D.'s IN MILITARY SERVICE:** *Members of the Veterans Administratian must be members at the State Medical Saciety ta be admitted.* Physicians in the armed services admitted by presenting certificatian of current military status.

★ **TELEPHONE SERVICE:** Registration Desk, Milwaukee Auditorium—271–9609. For Milwaukee MDs, Direct call through 273–7700, Ext. 200, and it will be relayed to a special phone near the main meeting hall at the Auditorium. For those at Luncheons: 5th Floor Foyer phone at Sheraton–Schroeder Hotel—271–7250. Tell your secretary the *raam number at the lunchean, sa we can lacate you!* (Your ticket has this information)

★ **RESERVATIONS FOR NOON LUNCHEONS:** For Round Tables, at registration desk between 8:00 a.m. and 11:00 a.m., starting Tuesday, May 14. If any tickets remain unsold by 11:30 a.m. the day of the luncheon, they can be purchased in fifth floor foyer, Sheraton–Schroeder Hatel.

★ **RESERVATIONS FOR ANNUAL DINNER:** May be obtained at the registration desk in the Auditorium from 8:00 a.m. to 4:00 p.m. Tuesday and Wednesday. Attendance at the dinner Wednesday night by ticket only. Limit 500.

NOTIFY YOUR SECRETARY AND HOME

A special phone will be installed at the Registratian Desk, Milwaukee Auditarium, through which you can be reached if you are attending the scientific programs.

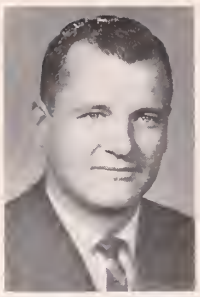
THIS NUMBER IS: (Area Cade 414)—271–9609

Times when you may be reached thru this phone:

Tuesday, May 14 and Wednesday, May 15: 8:30 a.m.-4:30 p.m.

Thursday, May 16: 8:30 a.m.–4:00 p.m.

TELL YOUR HOME AND SECRETARY WHERE YOU WILL BE SLEEPING, SO YOU CAN BE REACHED THERE AT OTHER TIMES WHEN YOU ARE IN MILWAUKEE.



THOMAS V. GEPPERT, MD
Chairman, Cammission an Scientific Medicine

OVID O. MEYER, MD
Program Chairman

ANNUAL MEETING PROGRAM

ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

THOMAS V. GEPPERT, M.D. _____ **Madisan**
Chairman

OVID O. MEYER, M.D. _____ **Madisan**
General Pragram Chairman

BEN R. LAWTON, M.D. _____ **Marshfield**
Scientific Exhibits

EDGAR S. GORDON, M.D. _____ **Madisan**
ALBERT MARTIN, M.D. _____ **Milwaukee**
R. A. STARR, M.D. _____ **Viraqua**
J. A. KILLINS, M.D. _____ **Green Bay**
A. V. PISCIOTTA, M.D. _____ **Milwaukee**
GERALD J. DERUS, M.D. _____ **Madisan**
EINAR R. DANIELS, M.D. _____ **Milwaukee**

Ex officia:

GERALD A. KERRIGAN, M.D. _____ **Milwaukee**
Dean, Marquette Schaal af Medicine

PETER L. EICHMAN, M.D. _____ **Madisan**
Dean, University of Wisconsin Medical Schaal

V. S. FALK, JR., M.D. _____ **Edgertan**
Medical Editar, *The Wisconsin Medical Jaurnal*

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

House of Delegates

The House of Delegates meetings are regarded as among the most important functions of the Society. Reports of the officers and committees, as well as new business, will be presented at the initial session. Reference committees will meet Tuesday morning, with reports to be made at the Tuesday evening session. The Nominating Committee will meet Tuesday afternoon and the third session, with election of officers, will be held on Wednesday morning.

Society members are urged to participate in the discussions on reports, resolutions, and nominations in the open hearings of the reference committees.

SCHEDULE

MONDAY, MAY 13

p.m.

6:00 BUFFET SUPPER for Delegates and Officers: East Room, 5th Fl. (S–S) and REGISTRATION for first session of House of Delegates, 5th Floor Foyer, Hotel Sheraton–Schroeder

7:00 FIRST SESSION, House of Delegates, Ballroom, 5th Floor, Hotel Sheraton–Schroeder

TUESDAY, MAY 9

a.m.

9:00 REFERENCE COMMITTEES: Hotel Sheraton–Schroeder
- Resolutions and Amendments: Ballroom (4th Fl.)
- Reports of Officers: Parlor G (4th Fl.)
- Reports of Standing Committees: Parlor H (4th Fl.)
- Finances: Parlor I (4th Fl.)

3:00 NOMINATING COMMITTEE: Room 504, 5th Floor, Hotel Sheraton–Schroeder

6:30 REGISTRATION for second session: 5th Fl. Foyer, Hotel Sheraton–Schroeder

7:30 SECOND SESSION, House of Delegates, Ballroom (5th Fl.), Hotel Sheraton–Schroeder

WEDNESDAY, MAY 10

a.m.

9:00 THIRD SESSION: Ballroom (5th Fl.), Hotel Sheraton–Schroeder

ANNUAL PHOTOGRAPHY EXHIBIT

Beautiful and exciting pictures taken by physicians. Awards will be made befare the Annual Meeting.

Woman's Auxiliary PROGRAM

MONDAY, MAY 13

P.M.

5:30 Pre-Convention Board Meeting and Dinner: Loraine Room, Hotel Sheraton–Schroeder

TUESDAY, MAY 14

A.M.

9:00 Registration and Continental Breakfast: Loraine Room, Hotel Sheraton–Schroeder

9:30 First Business Session: Loraine Room, Hotel Sheraton–Schroeder

P.M.

12:30 Luncheon: Wisconsin Club
Speaker: Paul Boesch, Houston Tex.—"The Womanly Art of Self Defense"

WEDNESDAY, MAY 15

A.M.

9:00 Registration and Continental Breakfast: Loraine Room, Hotel Sheraton–Schroeder

9:30 Second Business Session: Loraine Room, Hotel Sheraton–Schroeder

P.M.

12:30 Luncheon: Empire Room, Hotel Sheraton–Schroeder
Hixon's Informal Style Show
Installation of Officers, Mrs. C. C. Long, Ozark, Arkansas, President-Elect, Woman's Auxiliary to the A.M.A.

6:30 President's Reception (all those attending Annual Dinner, State Medical Society): East Room, Hotel Sheraton–Schroeder

7:15 Annual Dinner of the State Medical Society: Crystal Ballroom, Hotel Sheraton–Schroeder

MUSEUM OF MEDICAL PROGRESS AND STOVALL HALL OF HEALTH

Prairie du Chien, Wis.

Opens April 15

1968 ANNUAL MEETING PROGRAM

STATE MEDICAL SOCIETY OF WISCONSIN • MAY 14–16 • MILWAUKEE

TUESDAY, MAY 14

8:00—REGISTRATION AND VIEWING OF EXHIBITS

MILWAUKEE AUDITORIUM

MORNING GENERAL SCIENTIFIC PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

OSTEOPOROSIS

Chairman: EDGAR S. GORDON, MD, Madison

9:30—THE EFFECT OF AGE AND POSTMENOPAUSAL OSTEOPOROSIS ON THE INTESTINAL ABSORPTION OF CALCIUM

Louis V. Avioli, MD, St. Louis
Assistant Professor of Medicine, Washington University School of Medicine

10:00—FACTORS INVOLVED IN THE DEVELOPMENT OF OSTEOPOROSIS

Robert P. Heaney, MD, Omaha
Professor and Chairman, Department of Medicine, Creighton Univeristy School of Medicine

10:30—RECESS TO VIEW EXHIBITS

11:00—PANEL

Moderator: EDGAR S. GORDON, MD, Madison
Professor of Medicine, University of Wisconsin Medical School

Participants:
Louis V. Avioli, MD, St. Louis
Robert P. Heaney, MD, Omaha

AVIOLI

HEANEY

PETTY

BURROWS

HANAFEE

MARTEL

12:30—SCIENTIFIC LUNCHEONS

HOTEL SHERATON–SCHROEDER

INTERNAL MEDICINE

1. **THE DIFFERENTIAL DIAGNOSIS OF HYPERCALCEMIA**
   Louis V. Avioli, MD, St. Louis
   Chairman: Joseph A. Glennon, MD, Madison
   PARLOR B: FOURTH FLOOR

2. **MANAGEMENT OF THE PATIENT WITH SARCOIDOSIS**
   Benjamin Burrows, MD, Chicago
   Chairman: Edward K. Ryder, MD, Madison
   PARLOR D: FOURTH FLOOR

3. **DIAGNOSIS AND TREATMENT OF METABOLIC BONE DISEASE**
   Robert P. Heaney, MD, Omaha
   Chairman: Frank C. Larson, MD, Madison
   PARLOR C: FOURTH FLOOR

4. **PHILOSOPHY OF RESPIRATORY CARE**
   Thomas L. Petty, MD, Denver
   Chairman: Pending
   EAST ROOM: FIFTH FLOOR

OBSTETRICS AND GYNECOLOGY

5. **CHROMOSOMAL ASPECTS OF PREGNANCY WASTAGE**
   David Yi-Yung Hsia, MD, Chicago
   Chairman: Howard Lokietz, MD, Milwaukee
   ENGLISH ROOM: FIFTH FLOOR

6. **URETHRAL SUSPENSION**
   Richard F. Mattingly, MD, Milwaukee
   Professor and Chairman, Department of Obstetrics and Gynecology, Marquette School of Medicine
   PARLOR E: FOURTH FLOOR

7. **CLOMID—ONE YEAR LATER**
   Gloria E. Sarto, MD, Madison
   Associate Professor of Gynecology and Obstetrics, University of Wisconsin Medical School
   PARLOR F: FOURTH FLOOR

RADIOLOGY

8. **SELECTIVE ANGIOGRAPHY IN THE HEAD AND NECK**
   William N. Hanafee, MD, Los Angeles
   Chairman: Andrew B. Crummy, Jr., MD, Madison
   PERE–MARQUETTE ROOM: FIFTH FLOOR

9. **ASEPTIC NECROSIS OF BONE**
   William Martel, MD, Ann Arbor
   Chairman: Charles Benkendorf, MD, Green Bay
   PARLOR A: FOURTH FLOOR

TUESDAY *continued*

AFTERNOON SCIENTIFIC PROGRAMS

THREE PROGRAMS RUNNING CONCURRENTLY: Internal Medicine, Obstetrics and Gynecology, and Radiology

1. INTERNAL MEDICINE

JUNEAU HALL, MILWAUKEE AUDITORIUM
Chairman: EDWARD K. RYDER, JR., MD, Madison
Assistant Clinical Professor of Medicine, University of Wisconsin Medical School

2:00—THE NATURAL HISTORY AND PROGNOSIS OF OBSTRUCTIVE EMPHYSEMA
Benjamin Burrows, MD, Chicago
Professor of Medicine, University of Chicago School of Medicine

2:30—PULMONARY REHABILITATION
Thomas L. Petty, MD, Denver
Assistant Professor of Medicine, University of Colorado School of Medicine

3:00—RECESS TO VIEW EXHIBITS

3:30—PANEL
Moderator: JOHN RANKIN, MD, Madison
Professor of Medicine, University of Wisconsin Medical School
Participants:
Benjamin Burrows, MD, Chicago
Thomas L. Petty, MD, Denver
Helen A. Dickie, MD, Madison
Professor of Medicine, UW Medical School

2. OBSTETRICS AND GYNECOLOGY

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM
Chairman: JOSEPH C. FRALICH, MD, Racine

2:00—GAMMA GLOBULIN IN THE PREVENTION OF Rh. ISO-IMMUNIZATION
Serafeim P. Masouredis, MD, Milwaukee
Executive Director, Milwaukee Blood Center, Inc.

2:30—GENETIC FACTORS IN PREGNANCY WASTAGE
David Yi-Yung Hsia, MD, Chicago
Professor of Pediatrics, Northwestern University Medical School

3:00—RECESS TO VIEW EXHIBITS

3:30—OUR RESPONSIBILITY IN THE DEFINITION OF PATTERNS IN MATERNAL AND NEWBORN CARE
Ben M. Peckham, MD, Madison
Professor and Chairman, Department of Gynecology and Obstetrics, UW Medical School

4:00—PANEL
Moderator: JOSEPH C. FRALICH, MD, Racine
Participants:
Serafeim P. Masouredis, MD, Milwaukee
David Yi-Yung Hsia, MD, Chicago
Ben M. Peckham, MD, Madison

3. RADIOLOGY

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM
Chairman: ANDREW B. CRUMMY, JR., MD, Madison
Associate Professar of Radiology, UW Medical Schaol

2:00—SELECTIVE ANGIOGRAPHY IN THE HEAD AND NECK
William N. Hanafee, MD, Los Angeles
Professor and Chairman, Department of Radiology, University of California School of Medicine

2:30—THE SPONDYLITIS OF RHEUMATOID ARTHRITIS
William Martel, MD, Ann Arbor
Professor of Radiology, University of Michigan Medical Center

3:00—RECESS TO VIEW EXHIBITS

3:30—PANEL
Moderator: ANDREW B. CRUMMY, JR., MD, Madisan
Participants:
William N. Hanafee, MD, Los Angeles
William Martel, MD, Ann Arbor
John H. Juhl, MD, Madison
Professor of Radiology, UW Medical School
Morris B. Glover, MD, Madison
Assistant Professor of Surgery, UW Medical School

EVENING PROGRAMS

6:00—MARQUETTE ALUMNI DINNER
Milwaukee Athletic Club
Speaker: EDWARD R. ANNIS, MD, Miami, Fla.
Past President, American Medical Association

6:30—DINNER, Wisconsin Radiological Society
(Members only)
Milwaukee Yacht Club
Speaker: WILLIAM MARTEL, MD, Ann Arbor
"Practical Points in the Diagnosis of Joint Diseases"

NEW 50 YEAR CLUB MEMBERS

The fallawing will be hanared at a special dinner presented by the Cauncilars and Officers on Sunday, May 12, as new members af the 50 Year Club:

Edward S. Carlsson, MD ..... *La Crosse*
Joseph M. Freeman, MD ..... *Wausau*
Arthur F. Haag, MD ..... *Eau Claire*
T. Charles Hemmingsen, MD ..... *Racine*
Elgie M. Houghton, MD ..... *Lancaster*
Alfred N. E. Merten, MD ..... *Milwaukee*
George E. Moore, MD ..... *Antigo*
Aubrey H. Pember, MD ..... *Lake Wales, Fla.*
Hans Henrich Reese, MD ..... *Madison*
Chester C. Schneider, MD ..... *Milwaukee*
Oscar A. Stiennon, MD ..... *Green Bay*

WEDNESDAY, MAY 15

MORNING GENERAL SCIENTIFIC PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

9:30—USE OF COMPUTERS IN MEDICINE

Moderator:

C. Daniel Giesler, ScD, Madison
Associate Professor of Electrical Engineering, University of Wisconsin

Participants:

G. Phillip Hicks, PhD, Madison
Assistant Professor of Medicine, University of Wisconsin Medical School

Vincent C. Rideout, MS, Madison
Professor of Electrical Engineering, University of Wisconsin

Warner V. Slack, MD, Madison
Assistant Professor of Medicine and Professor of Computer Science, University of Wisconsin

10:30—RECESS TO VIEW EXHIBITS

11:30—PROMISING NEW DEVICES FOR USE IN MEDICINE

Moderator:

John G. Webster, PhD, Madison
Assistant Professor of Electrical Engineering and Instrumentation Systems, University of Wisconsin

Participants:

Edwin N. Lightfoot, PhD, Madison
Professor of Chemical Engineering, University of Wisconsin

John W. Mitchell, PhD, Madison
Associate Professor of Mechanical Engineering, University of Wisconsin

Stuart J. Updike, MD, Madison
Instructor in Medicine, University of Wisconsin

12:30-SCIENTIFIC LUNCHEONS

HOTEL SHERATON—SCHROEDER

ALLERGY

1. ALLERGIC DERMATOLOGIC MANIFESTATIONS OF ARTHROPOD EXPOSURE

Frank Perlman, MD, Portland, Ore.
Chairman: David M. Glassner, MD, Milwaukee
PARLOR B: FOURTH FLOOR

DERMATOLOGY

2. TREATMENT OF COMMON SKIN DISEASES

Arthur C. Curtis, MD, Ann Arbor
Chairman: Roger Laubenheimer, MD, Milwaukee
PERE—MARQUETTE ROOM: FIFTH FLOOR

INTERNAL MEDICINE

3. BIOMEDICAL ENGINEERING RESEARCH

C. Daniel Geisler, ScD, Madison
Chairman: J. L. Sims, MD, Madison
PARLOR D: FOURTH FLOOR

4. SOME PRACTICAL APPROACHES TO GERIATRIC PROBLEMS

William S. Middleton, MD, Madison
Professor of Medicine Emeritus, Dean of Medicine Emeritus, University of Wisconsin
EAST ROOM: FIFTH FLOOR

5. BIOMEDICAL INSTRUMENTATION

John G. Webster, PhD, Madison
Chairman: Ovid O. Meyer, MD, Madison
PARLOR E: FOURTH FLOOR

NEUROLOGY

6. FITS, FAKIRS AND FAKERS

J. Preston Robb, MD, Montreal, Canada
Associate Professor of Neurology and Neurosurgery, McGill University Faculty of Medicine
Chairman: Francis M. Forster, MD, Madison
ENGLISH ROOM: FIFTH FLOOR

OBSTETRICS AND GYNECOLOGY

7. VASCULAR PROBLEMS ASSOCIATED WITH PREGNANCY

Richard D. Sautter, MD, Marshfield
PARLOR A: FOURTH FLOOR

PEDIATRICS

8. IMMUNIZATIONS: PAST, PRESENT AND FUTURE

Vincent A. Fulginiti, MD, Denver
Chairman: William H. Bartlett, MD, Madison
PARLOR C: FOURTH FLOOR

AFTERNOON SCIENTIFIC PROGRAMS

FOUR PROGRAMS RUNNING CONCURRENTLY: Allergy, Dermatology, Neurology, and Pediatrics

1. ALLERGY

WALKER HALL, MILWAUKEE AUDITORIUM
Chairman: DAVID M. GLASSNER, MD, Milwaukee

2:00—EFFECTS OF NEBULIZED MEDICATION IN TREATMENT OF ASTHMA AND CHRONIC BRONCHOPULMONARY DISEASES

Frank Perlman, MD, Portland
Clinical Professor of Medicine and Chief of the Division of Immunology, Allergy and Infectious Diseases, University of Oregon Medical School

2:30—RECENT OBSERVATIONS OF PIGEON BREEDER'S DISEASE

Abe Sosman, MD, Milwaukee
Assistant Professor of Internal Medicine and Allergy, Marquette School of Medicine

2:50—ROUNDTABLE DISCUSSION
THE USE AND ABUSE OF NEBULIZED MEDICATION

Moderator: DAVID M. GLASSNER, MD, Milwaukee

Participants:

Frank Perlman, MD, Portland, Ore.
Richard Paul Jahn, MD, Milwaukee

3:15—RECESS TO VIEW EXHIBITS

3:30—CASE PRESENTATIONS: DIRE EFFECTS OF ABUSIVE SELF-ADMINISTERED NEBULIZED MEDICATION

David M. Glassner, MD, Milwaukee

HSIA

PERLMAN

CURTIS

ROBB

FULGINITI

NAJARIAN

2. *DERMATOLOGY*

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM
Chairman: JAMES W. BRINGE, MD, Sheboygan

2:00—COLLAGEN DISEASE AS SEEN BY THE DERMATOLOGIST
Arthur C. Curtis, MD, Ann Arbor
Professor of Dermatology, University of Michigan Medical School

2:30—SKIN DISEASES AGGRAVATED BY SUNLIGHT
Derek J. Cripps, MD, Madison
Assistant Professor of Dermatology, University of Wisconsin Medical School

3:00—RECESS TO VIEW EXHIBITS

3:30—PANEL
Moderator: JAMES W. BRINGE, MD, Sheboygan
Participants:
Arthur C. Curtis, MD, Ann Arbor
Derek J. Cripps, MD, Madison
Charles E. Reed, MD, Madison

3. *NEUROLOGY*

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM
Chairman: FRANCIS M. FORSTER, MD, Madison

2:00—CLINICAL DIAGNOSIS OF EPILEPSY
J. Preston Robb, MD, Montreal, Canada
Associate Professor of Neurology and Neurosurgery, McGill University Faculty of Medicine

2:30—ROLE OF ELECTROENCEPHALOGRAPHY IN THE DIAGNOSIS OF EPILEPSY
Francis M. Kruse, MD, Marshfield
Assistant Clinical Professor of Neurology, University of Wisconsin

2:45—NEUROPSYCHOLOGICAL EVALUATION OF THE EPILEPTIC PATIENT
Hallgrim Klove, PhD, Madison
Associate Professor of Neurology, Director, Neuro-Psychology Laboratory, Department of Neurology, University of Wisconsin Medical School
Charles G. Matthews, MD, Madison
Associate Professor of Neurology, University of Wisconsin Medical School

3:00—RECESS TO VIEW EXHIBITS

3:30—MEDICAL MANAGEMENT OF EPILEPSY
Philip T. White, MD, Milwaukee
Professor and Chairman, Department of Neurology, Marquette School of Medicine

4:00—SURGICAL MANAGEMENT OF THE EPILEPTIC
Flavio Puletti, MD, Madison
Associate Professor of Neurosurgery, University of Wisconsin Medical School

4:15—CONDITIONING IN CERTAIN CASES OF EPILEPSY
Francis M. Forster, MD, Madison
Professor and Chairman, Department of Neurology, University of Wisconsin Medical School

4:30—THE PHYSICIAN'S ROLE IN HANDLING THE SOCIAL IMPLICATIONS OF EPILEPSY
Jean P. Davis, MD, Milwaukee
Milwaukee Medical Clinic

4. *PEDIATRICS*

JUNEAU HALL, MILWAUKEE AUDITORIUM
Chairman: WILLIAM H. BARTLETT, MD, Madison
Clinical Instructor of Pediatrics, University of Wisconsin Medical School

2:00—THE INVESTIGATION AND TREATMENT OF GROWTH DISORDERS IN CHILDREN
George R. Kerr, MD, Madison
Assistant Professor of Pediatrics, University of Wisconsin Medical School

2:35—QUESTION AND ANSWER PERIOD

2:40—PEPTIC ULCER IN CHILDREN, A FAMILIAL DISEASE
Frederic M. Blodgett, MD, Milwaukee
Professor of Pediatrics, Marquette School of Medicine

3:10—QUESTION AND ANSWER PERIOD

3:15—RECESS TO VIEW EXHIBITS

3:30—A NEW LOOK AT IMMUNOLOGIC DEFICIENCY DISEASES
Vincent A. Fulginiti, MD, Denver
Associate Professor of Pediatrics, University of Colorado Medical Center

QUESTION AND ANSWER PERIOD
Vincent A. Fulginiti, MD, Denver
George A. Kerr, MD, Madison
Frederic M. Blodgett, MD, Milwaukee

ANNUAL DINNER

WEDNESDAY EVENING—MAY 15

As President of the State Medical Society, I am anxious to make this 127th Annual Meeting Dinner an outstanding success and that it be a fun evening for you and your wife. We will have superb entertainment with the University Singers, and we will be happy to honor our visiting guests and friends from other ancillary organizations. There will be no long speeches, so plan to attend and have fun.

Sincerely,

H. J. Kief, M.D.
President

PRESIDENT'S RECEPTION—6:30 P. M.

East Room: Hotel Sheraton–Schroeder

ANNUAL DINNER—7:15 P. M.

Ballroom: Hotel Sheraton–Schroeder

SPECIAL ENTERTAINMENT:

During the reception and the dinner we will be entertained by the John Clark Trio from the University of Wisconsin. Our entertainment for the evening will be the University Singers under the direction of Donald L. Neuen, Assistant Professor of Music, University of Wisconsin. This is an outstanding group as you will agree. Wait until you hear them.

$9.00 Per Person

MAKE RESERVATIONS BY MAIL OR AT REGISTRATION DESK BEFORE NOON, WEDNESDAY

THURSDAY, MAY 16

MORNING SPECIAL SCIENTIFIC PROGRAMS

FIVE PROGRAMS, SOME RUNNING CONCURRENTLY AND OTHERS CONTINUING THROUGHOUT THE DAY AND EVENING: Kidney Seminar, Surgery, Ophthalmology, Otolaryngology, and Resident–Intern

1. SEMINAR ON THE KIDNEY

(See box at bottom of page)

PERE–MARQUETTE ROOM: FIFTH FLOOR, HOTEL SHERATON–SCHROEDER

8:00 am–4:30 pm

Chairman: ROBERT O. BURNS, MD, Madison
Associate Professor of Medicine, University of Wisconsin Medical School

Richard E. Rieselbach, MD, Madison
Assistant Professor of Medicine, University of Wisconsin Medical School

Carl W. Trygstad, MD, Madison
Post-doctoral Fellow, Department of Pediatrics, University of Wisconsin Medical School

Special In-Depth Teaching Program covering physiology, pathology, and diseases of clinical interest. *LIMITED TO 30 PHYSICIANS.* ADVANCE REGISTRATION AND CONFIRMATION REQUIRED.

2. WISCONSIN SURGICAL SOCIETY

VETERANS ADMINISTRATION HOSPITAL, WOOD

8:00 am–12:00 m, continuing in afternoon and evening

WET CLINIC

Moderator:

Ben *R. Lawton, MD*, Marshfield

This is part of the all-day program of the Wisconsin Surgical Society and nonmember guests are welcome.

SEMINAR ON THE KIDNEY

THURSDAY, May 16—8:00 AM to 4:30 PM

For the first time in its scientific presentations during the Annual Meeting, the Commission on Scientific Medicine is presenting a pilot basic-science course on the kidney. This intensive seminar will cover the kidney, pursuing physiology, pathology, and diseases of clinical interest as seen by the faculty. It will cover both pediatric and older age groups and will lend itself not only to lectures but also to open discussion. If successful, and this program has been oversubscribed, similar basic science explorations of an organ or disease entity will be presented to a limited group of physicians in succeeding years. Please give your reactions to the Commission on Scientific Medicine. This year's program has been limited to 30 physicians on a first-come basis with a $25.00 registration fee.

3. *SECTION ON OPHTHALMOLOGY*

EAST ROOM, HOTEL SHERATON–SCHROEDER

9:00 am–12 m—CLINIC ON APPLANATION TONOMETRY

Chairman: RICHARD O. SCHULTZ, MD, Milwaukee
Associate Professor and Chairman, Department of Ophthalmology, Marquette School of Medicine

ENGLISH ROOM, HOTEL SHERATON–SCHROEDER

9:00 am–10:30 am;10:30 am–12 m—Two showings of a one and one-half hour movie program

Film Selector: GORDON L. BACKER, MD, Wausau

9:00 am–12:00 m—VISIT EXHIBITS AND EVENTS AT AUDITORIUM

FIFTH FLOOR LOBBY
Stereo–photographic exhibit.
OPHTHALMOLOGY DIVISION, University of Wisconsin Medical School

4. *OTOLARYNGOLOGY*

JUNEAU HALL, MILWAUKEE AUDITORIUM
Chairman: JOHN K. SCOTT, MD, Madison
Associate Clinical Professor of Surgery, University of Wisconsin Medical School

9:30—AN OTOLARYNGOLOGIST'S APPROACH TO FACIAL FRACTURES

Willis G. McMillan, MD, Madison
Clinical Instructor, Department of Otolaryngology; Attending Staff, V. A. Hospital

10:00—A SURGICAL APPROACH TO DEAFNESS

Michael M. Paparella, MD, Minneapolis
Professor and Chairman, Department of Otolaryngology, University of Minnesota School of Medicine

10:30—RECESS TO VISIT EXHIBITS

11:00—PANEL—A GROUP APPROACH TO HEARING AND SPEECH PROBLEMS IN CHILDREN

Moderator: MAXINE BENNETT, MD, Madison
Professor of Surgery and Chairman, Division of Otolaryngology, University of Wisconsin Medical School

Participants:
Michael M. Paparella, MD, Minneapolis
Stanley Ewanowski, PhD, Madison
Assistant Professor, Rehabilitation Medicine, Assistant Professor, Department of Communicative Disorders
Charles Tait, PhD, Madison
Assistant Professor, Department of Communicative Disorders

MAKE YOUR ROOM RESERVATIONS

On page 198, following this program, you will note a form to use for a room reservation at the Hotel Sheraton–Schroeder, Milwaukee. *Do not delay in making your reservation.*

10;00 MORNING SPECIAL PROGRAM

5. *RESIDENT-INTERN PAPERS*

This is a competitive program with cash awards of $100 each for the two winning presentations. One award known as the W. S. MIDDLETON AWARD and the second as the HARRY BECKMAN AWARD

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM
Chairman: THOMAS V. GEPPERT, MD, Madison
Chairman, Commission on Scientific Medicine

(Limited to 10 minutes per presentation.)

- **THE PROGRAMMED ACCELERATED LABORATORY INVESTIGATION (PALI) AND THE CLAS SYSTEM: ITS USE IN MULTIPHASIC SCREENING**
  David A. Barrett, II, MD, Milwaukee
  Resident in Pathology, St. Joseph's Hospital
- **HYPOTHYROID MYOPATHY—CLINICAL, BIOCHEMICAL, AND STRUCTURAL OBSERVATIONS**
  George A. Beller, MD, Madison
  Resident in Medicine, University Hospitals
- **SATURATION ANALYSIS: ITS BASIS AND A DEMONSTRATION OF ITS APPLICATIONS IN THE CLINICAL LABORATORY**
  William Faller, MD, Milwaukee
  Resident in Pathology, St. Joseph's Hospital
- **EXPERIMENTAL OBSERVATIONS ON ADULT GROWING SKULL FRACTURES**
  Larry M. Freeman, MD, Milwaukee
  Resident in Surgery, Marquette School of Medicine
- **INFLUENCE OF ELECTRICAL CURRENT ON RENAL ALLOGRAFT**
  Alexander Gunn, MD, Milwaukee
  Resident in Surgery, Milwaukee County General Hospital
- **STUDIES ON THE ENDOPLASMIC RETICULUM OF NORMAL RAT LIVER AND MINAL DEVIATION HEPATOMAS**
  Geoffrey H. Moyer, MD, Madison
  Resident in Pathology, University Hospitals
- **INCIDENCE AND IMPORTANT PARAMETERS OF SIGNIFICANT BACTERIURIA IN AN ADULT MALE HOSPITALIZED POPULATION**
  William E. Scheckler, MD, Madison
  Resident in Medicine, University Hospitals
- **NEUROPATHY IN CHILDREN**
  William M. Wanamaker, MD, Madison
  Resident in Medicine, University Hospitals
- **COMPLICATIONS OF RADICAL NECK DISSECTION**
  Francis W. Parnell, MD, Madison
  Resident in Otolaryngology, University Hospitals

ANNUAL MEDICAL ART SALON

An Auxiliary-sponsored event which is always a highlight of Annual Meeting exhibits.

THURSDAY *continued*

12:00-2:00—SPECIAL LUNCHEON

EAST ROOM, HOTEL SHERATON–SCHROEDER

SECTIONS ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Co-Chairmen:

JAMES V. BOLGER, MD, Milwaukee
Chairman, Section on Ophthalmology

JOHN K. SCOTT, MD, Madison
Chairman, Section on Otolaryngology

Combined luncheon of these two groups, followed by business meeting of *Section on Ophthalmology*. At this point, *Section on Otolaryngology* will adjourn to its own activities and business meeting at Juneau Hall, Milwaukee Auditorium.

12:30—SCIENTIFIC LUNCHEONS

HOTEL SHERATON–SCHROEDER

ANESTHESIOLOGY

1. THE PACEMAKER PATIENT: WILL THE CAUTERY TURN HIM OFF?
John M. R. Bruner, MD, Boston, Mass.
Chairman: Frederick D. Cook, MD, Green Bay
PARLOR D: FOURTH FLOOR

INTERNAL MEDICINE

2. HEADACHES
J. D. Kabler, MD, Madison
Associate Professor of Medicine, University of Wisconsin Medical School
PARLOR C: FOURTH FLOOR

3. NEWER DRUGS AND THEIR USES
Ovid O. Meyer, MD, Madison
Professor of Medicine, University of Wisconsin Medical School
PARLOR A: FOURTH FLOOR

4. NEW DRUGS AND THE TREATMENT OF VIRUS INFECTIONS
June E. Osborn, MD, Madison
Assistant Professor of Pediatrics, University of Wisconsin Medical School
PARLOR E: FOURTH FLOOR

5. ENGINEERING IN MEDICINE AND BIOLOGY
Anthony Sances, PhD, Milwaukee
Chairman: Ernest O. Henschel, MD, Milwaukee
PARLOR F: FOURTH FLOOR

ORTHOPEDIC SURGERY

6. SURGERY OF ARTHRITIS CONDITIONS
Hampar Kelikian, MD, Chicago
Chairman: Charles W. Christenson, MD, Racine
PARLOR B: FOURTH FLOOR

SURGERY

7. WHITHER HEART TRANSPLANTATION?
John S. Najarian, MD, Minneapolis
Chairman: Ben R. Lawton, MD, Marshfield
ENGLISH ROOM: FIFTH FLOOR

AFTERNOON SPECIALTY SCIENTIFIC PROGRAMS

FIVE PROGRAMS RUNNING CONCURRENTLY: Anesthesiology, Ophthalmology, Otolaryngology, Orthopedics, and Surgery

1. ANESTHESIOLOGY

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM
Chairman: FREDERICK D. COOK, MD, Green Bay

2:00—ELECTRICAL HAZARDS IN HOSPITALS
John M. R. Bruner, MD, Groton, Mass.
Assistant in Anesthesia, Massachusetts General Hospital and Harvard Medical School

2:30—PRESENT STATUS OF ELECTRO-ANESTHESIA
Anthony Sances, PhD, Milwaukee
Associate Professor of Neurosurgery, Associate Professor and Director of Biomedical Engineering, Marquette University and Marquette School of Medicine

3:00—RECESS TO VIEW EXHIBITS

3:30—PANEL
Moderator: FREDERICK D. COOK, MD, Green Bay
Participants:
John M. R. Bruner, MD, Groton, Mass.
Anthony Sances, PhD, Milwaukee

2. OPHTHALMOLOGY

EAST ROOM, HOTEL SHERATON–SCHROEDER
Chairman: JOHN B. HITZ, MD, Milwaukee
Clinical Professor, Department of Ophthalmology, Marquette School of Medicine

2:00—RECENT ADVANCES IN SERONEGATIVE OCULAR SYPHILIS
J. Lawton Smith, MD, Coral Gables
Associate Professor of Ophthalmology and Neurosurgery and Assistant Professor of Neurology, University of Miami School of Medicine, Fla.

3:00—CLINICO-PATHOLOGICAL CONFERENCE
Moderators:
Harry A. Easom, MD, Milwaukee
Assistant Clinical Professor, Department of Ophthalmology, Marquette School of Medicine
Guillermo de Venecia, MD, Madison
Assistant Professor of Surgery (Ophthalmology), University of Wisconsin Medical School

THURSDAY *continued*

3. OTOLARYNGOLOGY

JUNEAU HALL, MILWAUKEE AUDITORIUM
Chairman: FRANK G. TRESKOW, MD, Milwaukee
President, Wisconsin Otolaryngological Society

2:00—PATHOLOGY AND TREATMENT OF CHRONIC EAR DISEASE
Michael M. Paparella, MD, Minneapolis
Professor and Chairman, Department of Otorhinolaryngology, University of Minnesota School of Medicine
Followed by business meeting of Wisconsin Otolaryngological Society

4. ORTHOPEDICS

WALKER HALL, MILWAUKEE AUDITORIUM
Chairman: F. G. GAENSLEN, MD, Milwaukee

2:00—HALLUX VALGUS AND ALLIED PROBLEMS OF THE FOREFOOT
Hampar Kelikian, MD, Chicago
Professor Emeritus, Northwestern University School of Medicine
DISCUSSION

3:00—RECESS TO VIEW EXHIBITS

3:30—IMMEDIATE POSTOPERATIVE FITTING OF AMPUTEES
Alfred E. Kritter, MD, Waukesha
Assistant Clinical Professor, Marquette School of Medicine
DISCUSSION

5. SURGERY

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM
Chairman: ALBERT G. MARTIN, MD, Milwaukee
President, Wisconsin Surgical Society

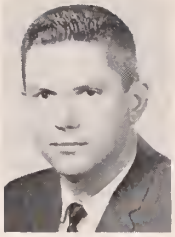
1:45—ULCERATIVE COLITIS AND CARCINOMA
William B. Gallagher, MD, La Crosse

2:00—CONGENITAL ANOMALIES OF THE THORACIC DUCT
Albert H. Pemberton, MD, Milwaukee
Associate Clinical Professor of Thoracic and Cardiovascular Surgery, Marquette School of Medicine

2:15—THE EFFECTS OF A NEW ANTIGASTRIN COMPOUND ON HYPERSECRETION IN THE DOG
Kenneth R. Tucker, MD, Milwaukee
Stuart D. Wilson, MD, Milwaukee

2:30 THE CURRENT STATUS OF TISSUE TRANSPLANTATION
John S. Najarian, MD, Minneapolis
Professor and Chairman, Department of Surgery, University of Minnesota School of Medicine

3:15—RECESS TO VIEW EXHIBITS


PAPARELLA

KELIKIAN

BRUNER

SMITH

3:35—PANEL: "MEET THE CHIEF"—SHARP DISSECTION OF THE ANATOMY AND PATHOLOGY OF MODERN SURGICAL EDUCATION
Moderator: ALBERT G. MARTIN, MD, Milwaukee
Participants:
Anthony R. Curreri, MD, Madison
Chief of Surgery, University of Wisconsin Medical School
Edwin H. Ellison, MD,
Chief of Surgery, Marquette School of Medicine
John S. Najarian, MD, Minneapolis
Chief of Surgery, University of Minnesota School of Medicine

4:30—ADDRESS OF INCOMING PRESIDENT
John T. Mendenhall, MD, Madison
Professor of Surgery, University of Wisconsin Medical School

EVENING PROGRAMS

1. WISCONSIN ORTHOPAEDIC SOCIETY

6:00—DINNER PROGRAM
(Location Pending)
Guest Speaker: HAMPAR KELIKIAN, MD, Chicago
Topic: *"Congenital Malformations of the Hand"*

2. SECTION ON OPHTHALMOLOGY

6:30—DINNER PROGRAM
UNIVERSITY CLUB
Chairman: WILLIAM H. BENNETT, MD, Racine
President, Milwaukee Ophthalmic Society
Guest Speaker: J. LAWTON SMITH, MD, Coral Gables
Topic: *"Some Neuro-Ophthalmologic Motility Problems"*

3. WISCONSIN SURGICAL SOCIETY

7:00—DINNER PROGRAM
MILWAUKEE ATHLETIC CLUB
Members and guests with wives.
Guest Speaker: SENATOR GAYLORD NELSON

RESERVATION FORMS FOR

Noon Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 2 Choices for each of the days you make reservations. List in order of preference. $3.00 per luncheon, including gratuities and taxes.

TUESDAY, MAY 14 (See page 189 for listing)

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. AVIOLI: The Differential Diagnosis of Hypercalcemia
2. BURROWS: Management of the Patient with Sarcoidosis
3. HEANEY: Diagnosis and Treatment of Metabolic Bone Disease
4. PETTY: Philosophy of Respiratory Care
5. HSIA: Chromosomal Aspects of Pregnancy Wastage
6. MATTINGLY: Urethral Suspension
7. SARTO: Clomid—One Year Later
8. HANAFEE: Selective Angiography in the Head and Neck
9. MARTEL: Aseptic Necrosis of Bone

Name of Leader: *Name of Leader*

First Choice: _____ Second Choice: _____

WEDNESDAY, MAY 15 (See page 191 for listing)

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. PERLMAN: Allergic Dermatologic Manifestations of Arthropod Exposure
2. CURTIS: Treatment of Common Skin Diseases
3. GEISLER: Biomedical Engineering Research
4. MIDDLETON: Some Practical Approaches to Geriatric Problems
5. WEBSTER: Biomedical Instrumentation
6. ROBB: Fits, Fakirs and Fakers
7. SAUTTER: Vascular Problems Associated with Pregnancy
8. FULGINITI: Immunizations: Past, Present and Future

Name of Leader: *Name of Leader*

First Choice: _____ Second Choice: _____

THURSDAY, MAY 16 (See page 195 for listing)

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

0. OPHTHALMOLOGY—OTOLARYNGOLOGY: Combined Luncheon
1. BRUNER: The Pacemaker Patient: Will the Cautery Turn Him Off?
2. KABLER: Headaches
3. OVID O. MEYER: New Drugs and Their Uses
4. OSBORN: New Drugs and the Treatment of Virus Infections
5. SANCES: Engineering in Medicine and Biology
6. KELIKIAN: (title pending)
7. NAJARIAN: Whither Heart Transplantation?

Name of Leader: *Name of Leader*

First Choice: _____ Second Choice: _____

ANNUAL DINNER, Wed., May 15

ENTERTAINMENT—COCKTAILS
SHORT SPEECHES—

$9.00 PER PERSON (Including Gratuities and Taxes)

Number Luncheon Tickets ($3.00 each) . . . . _____ for $_____

Number Annual Dinner Tickets ($9.00 each) . . _____ for $_____ TOTAL $_____

Make Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

NAME _____ STREET _____ CITY _____
(Print, please)

MAIL TO: State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701

OUT-OF-STATE GUEST SPEAKERS

LOUIS V. AVIOLI, MD, St. Louis, Mo.
Assistant Professor of Medicine, Washington University School of Medicine

JOHN M. R. BRUNER, MD, Boston, Mass.
Assistant in Anesthesia, Massachusetts General Hospital and Harvard Medical School

BENJAMIN BURROWS, MD, Chicago, Ill.
Associate Professor of Medicine, Department of Medicine, University of Chicago

ARTHUR C. CURTIS, MD, Ann Arbor, Mich.
Professor of Dermatology, University of Michigan Medical School

VINCENT A. FULGINITI, MD, Denver, Colo.
Associate Professor of Pediatrics, University of Colorado Medical Center

WILLIAM N. HANAFEE, MD, Los Angeles, Calif.
Professor and Chairman, Department of Radiology, University of California School of Medicine, Center for the Health Sciences

ROBERT P. HEANEY, MD, Omaha, Neb.
Professor and Chairman of Department of Medicine, Creighton University School of Medicine

DAVID YI-YUNG HSIA, MD, Chicago, Ill.
Professor of Pediatrics, Northwestern University Medical School

HAMPAR KELIKIAN, MD, Chicago, Ill.
Professor Emeritus, Northwestern University School of Medicine

WILLIAM MARTEL, MD, Ann Arbor, Mich.
Professor of Radiology, University of Michigan Medical Center

JOHN S. NAJARIAN, MD, Minneapolis, Minn.
Professor and Chairman of Department of Surgery, University of Minnesota Medical School

MICHAEL M. PAPARELLA, MD, Minneapolis, Minn.
Professor and Chairman of Department of Otolaryngology, University of Minnesota School of Medicine

FRANK PERLMAN, MD, Portland, Ore.
Clinical Professor of Medicine and Chief of the Division of Immunology, Allergy and Infectious Diseases, University of Oregon Medical School

THOMAS LEE PETTY, MD, Denver, Colo.
Assistant Professor of Medicine, University of Colorado Medical Center

J. PRESTON ROBB, MD, CM, Montreal, Canada
Associate Professor of Neurology and Neurosurgery, McGill University Faculty of Medicine

J. LAWTON SMITH, MD, Coral Gables, Fla.
Associate Professor of Ophthalmology and Neurosurgery, and Assistant Professor of Neurology, University of Miami

MAKE YOUR HOTEL RESERVATIONS NOW

STATE MEDICAL SOCIETY OF WISCONSIN
MAY 14 - 16, 1968

PLEASE CHECK ACCOMMODATIONS DESIRED (All rates subject to 3% state tax)

	1 PERSON Single Occupancy	2 PERSONS Double Occupancy	1 BEDROOM SUITE
LUXURY	☐ 14.00	☐ 18.00	☐ 38.00
STANDARD	☐ 12.50	☐ 16.50	☐ 33.00
ECONOMY	☐ 11.00	☐ 15.00	
STUDIO SINGLE	☐ 9.50		

TWO BEDROOM SUITE $56.00 ☐

NOTE: $3.00 CHARGE FOR EACH ADDITIONAL PERSON IN ROOM

Arrival Date _____ Specify Arrival Time _____ Departure Date _____

NAME _____

STREET _____

CITY _____ STATE _____ ZIP _____

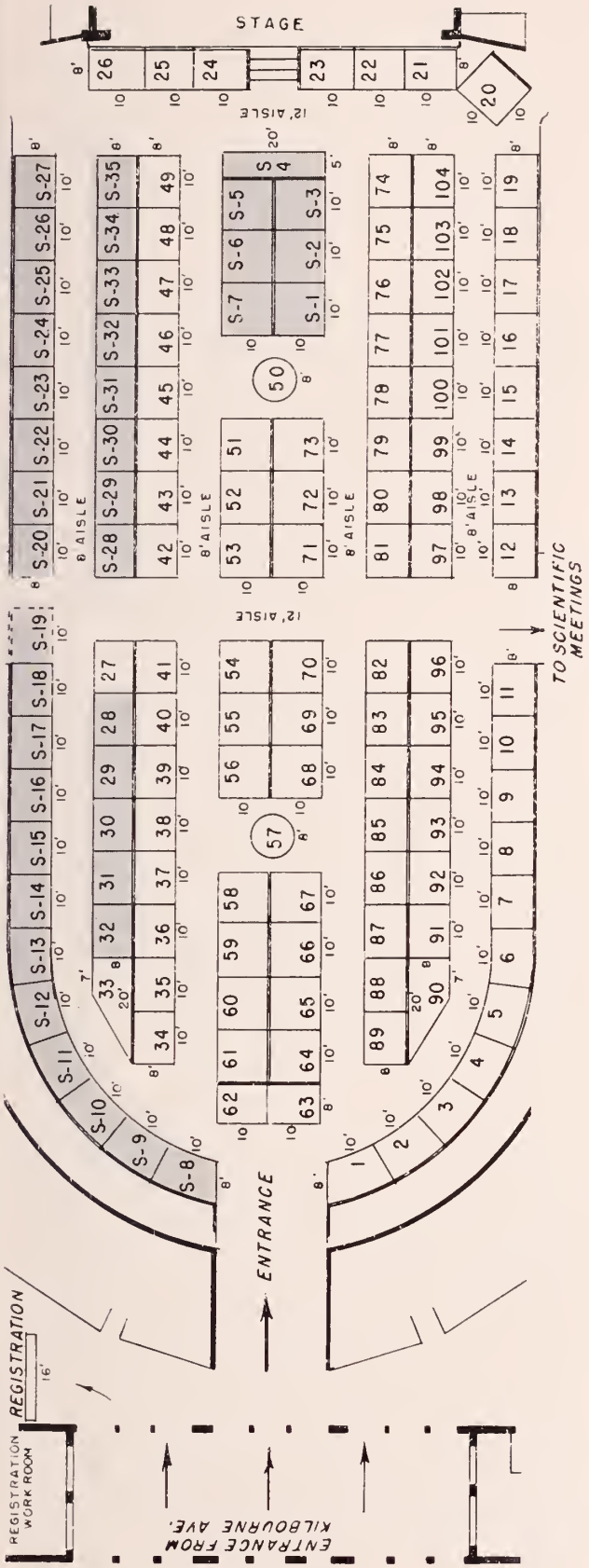
Organization or Firm _____

Credit Card _____ No. of Credit Card _____

For Your Convenience: — AIR CONDITIONED ROOMS — 2 RESTAURANTS — FREE PARKING — ICE FREE
Rooms will be held until 6 p.m. unless otherwise noted

SHERATON - SCHROEDER HOTEL
"WISCONSIN'S LARGEST"

509 WEST WISCONSIN AVENUE
MILWAUKEE, WISCONSIN
PHONE (414) 271-7250



Scientific Exhibits

MILWAUKEE AUDITORIUM

EXHIBIT HOURS

Tuesday, May 14	8:00 am–5:00 pm
Wednesday, May 15	8:30 am–5:00 pm
Thursday, May 16	8:30 am–3:45 pm

(Exhibits "break up" at 3:45 pm on Thursday, May 16)

THIS GROUP IN AREA S-1 THROUGH S-7 ON CHART

THE CHILDREN OF THE WORLD DESERVE TO BE PLANNED

Planned Parenthood Association of Milwaukee and Medical Advisory Committee, Roland S. Cron, MD, Chairman

Table top exhibit of educational, scientific and patient literature on family planning, developed by the American Association of Planned Parenthood Physicians and Planned Parenthood-World Population. Exhibit will be in good taste, materials not duplicating pharmaceutical companies' publications. Photographs and/or posters will decorate rear and sides of booth. Purpose is to aid the specialist and physician in general practice in communicating effectively with patients on the subject of the sexual relationship in marriage, infertility, child spacing, and family planning.

UTILIZATION OF GROUP THERAPY

Basilio Lopez, MD, John M. Littnan, BS, Ann Marie Budde, BSN, in cooperation with the Department of Physical Medicine, Sacred Heart Rehabilitation Hospital, Milwaukee

It is the purpose of this exhibit to present a program for physical rehabilitation that would embrace:

1. The dynamics of human relationships within a group.
2. Group therapy as a compliment to the traditional approach.
3. Utilization of ancillary personnel to enhance the efficiency of the therapist.

Generally, when one surveys behavior it is the group structure which appears basic in most relationships in the family, school, church and community. Therefore, the group approach provides a natural setting for the rehabilitative process, and creates an environment which is advantageous for patient and personnel. At Sacred Heart Rehabilitation Hospital, Milwaukee, through a coordinated team effort, the ideal of rehabilitation as a round-the-clock teaching process can be achieved because the efforts and knowledge of the specially trained therapists have been multiplied through the use of assistance, and the motivation and cooperation of the patient has been sustained through the use of the group.

THE INTERACTION OF MEDICINE AND TECHNOLOGY AT THE UNIVERSITY OF WISCONSIN

C. D. Geisler, ScD, Department of Electrical Engineering, College of Engineering, University of Wisconsin, Madison

The exhibit will include a LINC-8 computer for use in medical-history taking and laboratory-test analysis, and a cold-probe for use by surgeons.

EVOKED BRAIN POTENTIALS IN MAN: NEUROLOGICAL AND NEUROSURGICAL APPLICATIONS

Sanford J. Larson, MD, Department of Neurosurgery, Marquette School of Medicine, Milwaukee

Conventional radiological methods for localizing various areas of the brain depend on the accuracy of the stereotaxic apparatus and the spatial relationship of the areas to radiographically demonstrable landmarks. Because of normal anatomical variability, such localization is insufficiently accurate, particularly since the target areas are often 0.5 to 1.0 cm in diameter or even smaller. This exhibit presents a method for recording and evaluating human evoked potentials from the scalp, cerebral cortex, and subcortical structures, such as ventralis posterior lateralis (VPL-sensory relay nucleus), ventralis anterior (VA), centre median (CM), and ventralis lateralis (VL). Although Richard Caton had first recorded evoked potentials in 1875 using a galvanometer in the rabbit, and Dawson had performed pioneering work in man, the advent of the averaging computer has made evoked potential recording in man applicable to large-scale study.

MILWAUKEE CHILDREN'S HOSPITAL JUVENILE AMPUTEE CENTER

Alfred E. Kritter, MD, Milwaukee Children's Hospital

The exhibit will consist of photographic and diagramatic illustrations of the team concept of the Juvenile Amputee Center. The disciplines of the team will be represented by the surgeon, physical therapist, orthotist–prosthetist, and the social services. Routine and problem cases will be demonstrated.

TECHNIQUE OF VEIN STRIPPING

James M. Sullivan, MD, Columbia Hospital, Milwaukee

The indications and complications of vein stripping will be shown on fixed panels, and a movie, which we will attempt to cut down to eight minutes, showing the technique of vein stripping together with a commentary which will be put on a magnetic tape and can be run concurrently with the movie. The location of perforating branches and their ligations will be shown in the movie. Positioning the patient on the table will also be shown.

TERMINAL NEPHRITICS DO NOT HAVE TO DIE: HOME DIALYSIS SCHOOL AT ST. MICHAEL AND DEACONESS HOSPITALS

The Milwaukee Dialysis Association, St. Michael Hospital and Deaconess Hospital, Frank E. Berridge, Jr., MD, James A. Means, MD, Andrew A. Pandazi, MD, John T. Sullivan, Jr., MD, and Lee H. Thompson, MD, Milwaukee

The exhibit will consist of three exhibition boards along the back of the booth demonstrating the methodology of inserting an A–V shunt, particularly the straight line in the leg; a report of the 32 cases thus far treated; and a report on the method of handling complications. The third table will demonstrate how to stay out of the poorhouse while on dialysis and awaiting cadaveric transplant by means of home dialysis. In front of these spaces there will be an exhibit which will consist of a mannequin and an artificial kidney, the recirculating single pass type built as a link trainer utilized in training relatives of patients to run said patients on the artificial kidney without involving the patient himself or herself in the setup.

THIS GROUP IN AREA S-8 THROUGH S-19 ON CHART

WISCONSIN HEART ASSOCIATION PHYSICIAN INFORMATION AND EDUCATION

Wisconsin Heart Association, Milwaukee

The exhibit consists of three revolving panels depicting in graphics and copy the scientific sessions, physician programs, and the benefits of physician membership in WHA. A header connects the three panels at the top, and the motor which turns the panels is housed in a casing at the base.

REVASCULARIZATION OF THE ISCHEMIC LEG

Dean A. Emanuel, MD, Marshfield Clinic Foundation, St. Joseph's Hospital, Marshfield

The exhibit will show a new treatment for arterial obstruction of the leg first described by C. T. Dotter and M. P. Judkins. The technique utilizes dilating catheter in the femoral artery which molds and radically displaces the atheromatous material. Indications are impending or actual gangrene and severe ischemic pain. Fifty per cent of patients facing amputation will be helped and in some cases where surgery is necessary it may reduce the extent of the amputation. The procedure is particularly useful in the elderly diabetic. The technique and results of the procedure will be shown.

ADVANCES IN PREVENTION OF TUBERCULOSIS

Wisconsin Anti-Tuberculosis Association, Milwaukee

Wisconsin is in the forefront of the fight against the age old disease of tuberculosis. The WATA's exhibit, prepared especially for this convention, concentrates on advances in the fight against TB. Particular attention is paid to the progress that has been made through the use of chemoprophylaxis.

THE RHEUMATOID HAND

Thomas J. Flatley, MD, Department of Orthopedic Surgery, Marquette School of Medicine, Milwaukee

Emphasis is placed on the medical management of the rheumatoid hand. If this fails, however, the exhibit will show how surgery offers hope of salvaging the hand. A short summary of the medical management will occupy one board. In the center color photographs and x-rays will depict the disease along with surgical correction. On the left a summary of the rationale of treatment will be given.

FOUR PROGRAMS OF CARE ASSOCIATED WITH A HOSPITAL

James D. M. Russell, Associate Administrator, Luther Hospital, Eau Claire

Posters, color slides, and pictures describing the Coronary Care Unit, the Suicide Prevention Center, the Telecare Service, and the Pediatric Orientation Program at Luther Hospital.

PERCUTANEOUS NEEDLE BIOPSY OF THE THYROID

Thomas F. Nikolai, MD, Marshfield Clinic Foundation, Marshfield

Needle Biopsy of the Thyroid is a simple technique which can be carried out in the physician's office. This exhibit will demonstrate in a step-by-step illustrated fashion the technique associated with Percutaneous Biopsy. The indications for this diagnostic study will be given and the classic histologic pictures seen in Struma Lymphomatosa, Subacute Thyroidism, Multinodular Goiter, and Anaplastic Carcinoma will be illustrated. The results of the series carried out in the Department of Endocrinology at the Marshfield Clinic will be presented.

STEREOTACTIC SURGERY IN PARKINSON'S DISEASE

Flavio Puletti, MD, Division of Neurological Surgery, University of Wisconsin, Madison

The exhibit consists of 3 plywood panels. There will be a continuous film exhibiting patients and details of the operative technic. There will also be photographs and anatomical diagrams of the structure where the lesion is placed. Tables listing the indications and contraindications to surgical treatment of Parkinson's disease will be exhibited.

CARPAL TUNNEL SYNDROME (MEDIAN NERVE COMPRESSION AT WRIST LEVEL)

Jack L. Teasley, MD, William H. Frackelton, MD, and Donald M. Levy, MD, Milwaukee

With this exhibit, the authors wish to call attention to a relatively common condition. Compression of the median nerve within the carpal tunnel may be due to a number of causes. These causes are presented. The patient's complaints and physical findings are listed and treatment is described.

ULCERS IN CHILDHOOD

Margaret Prouty, MD and Dorothy W. Oakley, MD, Jackson Clinic, Madison

We wish to make the point that ulcers in childhood are common and commonly missed. Material will be presented to show age and sex distribution, common complaints, physical findings, personality types, family background, and treatment (based on the presentation of approximately 300 verified ulcers.)

WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

Wisconsin State Medical Assistants Society

This exhibit consists of a display of handout materials and several posters explaining the purpose of the Society in relation to helping the Doctors of Wisconsin. Information will be exhibited regarding the Medical Assistant Training Schools in Wisconsin. Experienced medical assistants will be in attendance to answer any questions.

ELECTRON MICROSCOPY OF NEOPLASMS

American Cancer Society, Milwaukee Division and Wisconsin Division, in cooperation with the Department of Pathology, Marquette School of Medicine, Milwaukee

This exhibit shows a series of labeled electron micrographs which illustrate neoplastic changes.

THE MONTEGGIA FRACTURE IN CHILDREN

R. C. Waisman, MD and G. N. Guten, MD in cooperation with Milwaukee Children's Hospital, Department of Orthopedic Surgery, and Marquette School of Medicine

The Monteggia fractures (fracture of the proximal ulna with dislocation of the radial head) have been reviewed at Milwaukee Children's Hospital for the last 25 years. Seventeen cases were reviewed. The exhibit will have three essential parts: (1) A description of the basic pathology of the Monteggia fracture in anatomic and radiographic terms, (2) An analysis of the epidemiology of the Monteggia fracture in terms of mechanism of injury, age, sex and method of treatment, and (3) A presentation of typical cases in terms of unknown x-rays with answers available to test the Doctor's diagnostic ability and to call to their attention the important x-ray criteria of the Monteggia fracture. A slide projector will be used to show the case histories, method of treatment, and pre- and postoperative x-rays of the 17 cases reviewed.

THIS GROUP FROM S-20 THROUGH S-27 ON CHART

ESSENTIALS OF THE EYE EXAMINATION

John W. Doty, MD, David G. Harper, MD, and David E. Stinchcomb, MD, University of Wisconsin Hospitals, Ophthalmology Section, Madison

Comprised of external and fundus photographs, illustrating adequate techniques for performing a screening examination for eye disease. Also included will be a short movie and/or slide-showing dealing with this subject. Emphasis will be placed on screening for amblyopia and glaucoma.

VENEREAL DISEASE IN WISCONSIN

Peter K. Mayville, Wisconsin Division of Health, Bureau of Preventable Diseases, Section of Venereal Disease Control, Madison

Card tables in front of exhibit, on which literature will be placed. Maps, charts, etc. to hang at rear of exhibit.

OCCULT TEMPORAL ARTERITIS

W. E. Meisekothen, MD, Ophthalmology Department, University Hospitals, Madison

Forty per cent (40%) of all patients with occult temporal arteritis will have visual loss ranging from partial in one eye to total binocular blindness. The internist and family physician are usually the first to see these

patients. All clinical aspects of this disease including colored photographs of the ophthalmological and pathological findings are presented. Treatment and diagnostic surgical biopsy are outlined. Several typical case histories showing the importance of early diagnosis are available.

SIX SLIDE TECHNIQUE IN BREAST CYTOLOGY

Teruo Masukawa, MD, in cooperation with Marquette School of Medicine, Milwaukee County General Hospital, Milwaukee Division of American Cancer Society, and The Johns Hopkins Medical Institutions

Physician routine breast examination and patient self-breast examination are equally important for early detection of breast cancer, the most common malignancy in American women. Recently, mammography and breast cytology have become diagnostic adjuncts. This exhibit illustrates the obtaining of breast cytology specimens using six or more slides. The causes of abnormal breast secretion are explained and representative cases are shown with cytological and histopathological color plates. This is a three-panel, self-standing exhibit. The center panel contains several drawings to illustrate the technique. The left panel has three lettered boards. The right shows 4 case reports with 8 cytological and 8 histological color transparencies with illumination. The center panel has a box, with take-home leaflets.

SURGERY FOR CORONARY ARTERY DISEASE

W. Dudley Johnson, MD, Derward Lepley, Jr., MD, John Huston, MD, John Manley, MD, and John A. Walker, MD, in cooperation with Department of Cardiac Surgery, Marquette School of Medicine, Department of Cardiology and Cardiac Surgery, St. Luke's Hospital, Milwaukee

This exhibit will explain and illustrate most facets involved in the surgery of coronary disease. Included will be a listing of indications for selective coronary studies, as well as reproductions of normal coronary angiograms. Brief case reports of patients with the normal angiograms will be given, to illustrate the necessity of these studies to exclude the diagnosis of coronary disease. Indications and contraindications for the three types of surgery for coronary disease will be illustrated. The three areas of surgery include revascularization procedures, ventricular aneurysm surgery, and direct arterial reconstruction using either patch grafts or vein bypass grafts for occluded areas. Brief case reports from each type of surgery will be presented. These reports will include reproductions of chest films, pre- and post-operative cine angiograms, and operative photographs. A summary of our cumulative results in each area of surgery will be presented.

THE DIAGNOSIS OF NEUROGENIC BLADDER

John B. Wear, Jr., MD, University of Wisconsin Medical School, Madison

It has been estimated that 5% to 10% of all patients with urinary symptoms have some type of neurogenic bladder. This diagnosis, however, is rarely made since the condition is so poorly understood by most physicians. The old-fashioned classification into "spastic bladder" and "flaccid bladder" has compounded the confusion by mixing neurogenic and non-neurogenic disease entities and conditions. This exhibit presents a practical classification of neurogenic bladder which is based on the location of the neurological lesion and its involvement of motor and/or sensory tracts. The terms applied are descriptive of the way the bladder behaves in each of the five types of neurogenic bladder. The causes, characteristics, and cystometrographic findings of each type of neurogenic bladder are presented. The diagnostic importance of the residual urine, the type of urinary incontinence, and the voiding pattern are stressed. It is hoped that a greater awareness of neurogenic bladder will result in its more frequent and accurate diagnosis.

THE PATTERN OF PORPHYRIA

Derek J. Cripps, MD, Sture A. M. Johnson, MD, Henry A. Peters, MD, and Arthur D. Daily, MD, in cooperation with the University of Wisconsin Medical School, Madison

The purpose of the exhibit is to present color transparent photographs of the main clinical, pathological, fluorescence microscopy and biochemical differences in erythropoietic porphyria, erythropoietic protoporphyria, and porphyria cutanea tarda—selected as porphyrias associated with photosensitivity. Quantitative porphyrins that we detected in the urine, stool, and erythrocytes *in all* the various porphyrias are illustrated.

Erythropoietic porphyria: (Since 1874, 64 cases, 35 M and 29 F) Fluorescence microphotographs illustrate 5% fluorocytes in peripheral blood half nucleated; fluorescence greater in the nuclei (uroporphyrin) than in the cytoplasm. *Erythropoietic protoporphyria:* (Since 1961, 100 cases, 65 M and 35 F) Fluorocytes in the blood ranged from 7% to 25% in 10 cases. Fluorescence of normoblasts in the marrow was limited to the cytoplasm (protoporphyrin). In the liver, protoporphyrin fluorescence is shown to be focal in 6 or 7 cases and occurs as brown pigment on H & E stains. Six cases had cholecystitis and gallstones may occur from deposition of this poorly soluble protoporphyrin; (350 μg/gm dry wt.) *Porphyria cutanea tarda:* (Relatively common) Plethoric, increased hemoglobin and hematocrit, skin fragility on exposed areas, impaired liver function with iron in the liver and bone marrow. Patients may improve clinically and with a decrease in porphyrin excretion, after repeated phlebotomy.

THIS GROUP FROM S-28 THROUGH S-35 ON CHART

CULDOTOMY—A METHOD OF EVALUATING PELVIC PATHOLOGY

F. J. Hofmeister, MD, William E. Martens, MD, and Ronald L. Streble, MD, in cooperation with Lutheran Hospital of Milwaukee

The method, technique and results of culdotomy as a method of evaluating pelvic pathology are described by illustrations, colored pictures, and personal description. It is thought that a more positive evaluation of pelvic masses could conceivably result in an earlier malignancy of the ovary and, consequently, increased curing.

FEEDING PHARYNGO-ESOPHAGOSTOMY

James H. Brandenburg, MD, Department of Otolaryngology, University of Wisconsin Medical Center, Madison

The exhibit will be arranged in three panels. In the center panel will be a continuous color movie showing a pharyngoesophagostomy operation being performed.

One side panel will present the indications for this procedure and the other side panel will outline the surgical technique.

WISCONSIN SOCIETY OF PATHOLOGISTS

Gordon E. Lang, MD, Wisconsin Society of Pathologists

The 1968 exhibit of the Wisconsin Society of Pathologists will feature a demonstration on automated multiphasic screening. Audio-visual tape recordings will be utilized.

ROENTGEN FEATURES OF ENDOMETRIOSIS OF THE COLON

John Matsis, MD and Richard Kessler, MD, in cooperation with St. Joseph's Hospital, Milwaukee

The purpose of this exhibit is to demonstrate the roentgen features of endometriosis involving the colon. Differentiation between colonic endometriosis and cancer will be emphasized. Several examples of regression following hormonal therapy will be presented.

THE PALI AND THE CLAS SYSTEMS

Charles H. Altshuler, MD, John Bareta, MD, Anthony F. Cafaro, MD, John R. Cafaro, MD, and Glenn Fellows, PhD, in cooperation with St. Joseph's Hospital, Milwaukee

A programmed accelerated laboratory investigation (PALI) is detailed and its implementation by the use of a digital computer is described. The analytic work was performed on a variety of automated instruments which were interfaced with a computer of the LINC type. A Calcomp 565 plotter is particularly useful as an output device when a graphic presentation of the data is required.

THIS GROUP IN AREA 28 THROUGH 32 ON CHART

REGIONAL MEDICAL PROGRAMS EXHIBIT

The Wisconsin Regional Medical Program, Inc. in cooperation with the Division of Regional Medical Programs, National Institutes of Health, Bethesda, Md.

The exhibit outlines the objectives, activities, and progress of Regional Medical Programs and includes a map indicating and identifying both planning and operational programs currently under way. It is a four-panel exhibit in color and has panel lighting at the top of each of the panels. There is space at the side of the exhibit for brochures with explanatory material.

LUNCHEON RESERVATIONS

See page 197 for speakers and topics. *Attendance limited*, so select the luncheons you wish to attend, and make reservations *immediately*.

DIVISION OF HEALTH SERVICES TO PHYSICIANS

Division of Health, Wisconsin Department of Health and Social Services, Madison

The exhibit will depict services to physicians of several sections of the Division of Health. Plans are to show this on free-standing, eight-panel, wood-framed, display units. Programs to be depicted are laboratory evaluation, PKU, communicable disease control, and occupational health.

LENGTH OF STAY REVIEW

Sidney Shindell, MD, in cooperation with the Health Service Data of Wisconsin, Inc., and Marquette School of Medicine, Milwaukee

The exhibit describes the simplicity of a computerized aid to Utilization Committees. Medical staffs are furnished with comparative data with which to identify areas warranting review in their hospital, and as a byproduct all the indexes required for Joint Commission accreditation are supplied the record room. The service described is that of Health Service Data of Wisconsin, Inc., a non-profit organization made up of designees of the 20 organizations in Wisconsin having primary concern with hospital care and its cost, including both the State and Milwaukee County medical societies, Wisconsin Hospital Association, and both Wisconsin medical schools. The service of HSD is unique in that it is locally sponsored and provides local comparisons for use by utilization committees. Endorsed by the Milwaukee Hospital Council as "The Program of Choice," the program has enrolled 21 hospitals in its first year of operation. The exhibit consists of three panels depicting the components of the service.

THIS EXHIBIT ON NORTHWEST DELIVERY ENTRANCE

Special Scientific Exhibit

OTOMOBILE—MOBILE OTOLOGIC UNIT

Recently the Crippled Children Division of the Bureau for Handicapped Children, State Department of Public Instruction, purchased a self-propelled mobile clinic to be used in the Hearing Conservation Program. This is a unique vehicle which will provide better facilities for holding otologic clinics. The unit will be on display during the Annual Meeting and representatives of the Division will be on hand to explain the entire hearing conservation program.

Because of its size, the Otomobile could not be placed inside the Auditorium with the rest of the exhibits. It may be seen directly outside the Auditorium at the loading dock ramp—proceed directly north through the northwest freight entrance.

Don't miss the opportunity to visit and see what can be accomplished in this specially equipped vehicle by way of screening for hearing defects and testing of patients on a completely mobile basis.

Technical Exhibits

22—ABACUS, INC., Janesville
81—ABBOTT LABORATORIES, North Chicago, Ill.
86—AMERICANA CORPORATION, Chicago, Ill.
46—ARNAR–STONE LABORATORIES, INC., Mount Prospect, Ill.
66—ASTRA PHARMACEUTICAL PRODUCTS, INC., Worcester, Mass.
45—AUTOMATED BILLING CONTROL, Milwaukee
62—AYERST LABORATORIES (Division of American Home Corp.), New York, N. Y.
95—BACHE AND COMPANY, Milwaukee
37—BEECHAM RESEARCH LABORATORIES, New York, N. Y.
104—BENCO OPHTHALMIC LABORATORIES, INC., Milwaukee
97—THE BORDEN COMPANY (Pharmaceutical Division), New York, N. Y.
73—BREON LABORATORIES, INC, New York, N. Y.
96—BURROUGHS WELLCOME & COMPANY, INC., Tuckahoe, N. Y.
34—CARNATION COMPANY, Los Angeles, Calif.
71—CIBA PHARMACEUTICAL COMPANY, Summit, N. J.
50—THE COCA COLA COMPANY, Skokie, Ill.
13—CREATIVE SYSTEMS, INC., Waterloo, Ia.
65—D. M. DOYLE PHARMACEUTICAL COMPANY, Minneapolis, Minn.
12—EATON LABORATORIES, Norwich, N. Y.
24—ECONO LEASE, INC., Milwaukee
17—ENCYCLOPEDIA BRITANNICA, Chicago, Ill.
53—MARSHALL ERDMAN & ASSOCIATES, INC., Madison
79—THE A. J. FARNHAM COMPANY, INC., Milwaukee
83—H. G. FISCHER & COMPANY, Franklin Park, Ill.
23—GORDON FLESCH COMPANY, INC., Madison
88—FLINT LABORATORIES, Morton Grove, Ill.
87—FRANK E. FRYER COMPANY, Carpentersville, Ill.
68—GEIGY PHARMACEUTICALS (Div. of Geigy Chemical Corp.), Ardsley, N. Y.
64—GENTEC HOSPITAL SUPPLY COMPANY, Milwaukee
90—HANDICABS OF MILWAUKEE, Milwaukee
92–93—HOECHST PHARMACEUTICAL COMPANY, Cincinnati, Ohio
42—HURLEY X-RAY COMPANY, Milwaukee
26—IMPERIAL FASHIONS, INC., Los Angeles, Calif.
4—KREMERS–URBAN COMPANY, Milwaukee
25—LAAB'S, INC., Milwaukee
78—LA CROSSE MEDICAL SUPPLY COMPANY, La Crosse
5—LAKESIDE LABORATORIES, INC., Milwaukee
35—LANGER LABORATORIES, INC., Milwaukee
3—LEDERLE LABORATORIES, Pearl River, N. Y.
43—ELI LILLY AND COMPANY, Indianapolis, Ind.
10—J. B. LIPPINCOTT COMPANY, Philadelphia, Pa.
49—LITTLE PRESS, INC., Minneapolis, Minn.
38—LOMA LINDA FOODS, Riverside, Calif.
19—3-M BUSINESS PRODUCTS SALES, INC., Milwaukee
55—MARION LABORATORIES, INC., Kansas City, Mo.
56—MEAD JOHNSON LABORATORIES, Evansville, Ind.
1—MEDICO MART, INC., Milwaukee
72—MEDICAL PROTECTIVE COMPANY, Fort Wayne, Ind.
69–70—MERCK SHARP & DOHME, West Point, Pa.
52—MILEX CENTRAL, Glenview, Ill.
80—MONARCH LIFE INSURANCE, Madison
9—MUTUAL BENEFIT LIFE INSURANCE COMPANY, Madison
15—NEW YORK LIFE, Milwaukee
82—JOHN NICHOLS, INC., Milwaukee
36—ORGANON, INC., West Orange, N. J.
27—ORTHO PHARMACEUTICAL CORPORATION, Raritan, N. J.
14—PACE, Waterloo
54—PARKE, DAVIS & COMPANY, Detroit, Mich.
91—PFIZER LABORATORIES, New York, N. Y.
85—PHYSICIANS & HOSPITALS SUPPLY COMPANY, Minneapolis, Minn.
44—PICKER–NUCLEAR, Chicago, Ill.
98—PLEASONING, La Crosse
6—PROFESSIONAL BUSINESS SERVICE, La Crosse
41—ROCHE LABORATORIES (Div. of Hoffman–LaRoche, Inc.), Nutley, N. J.
2—J. B. ROERIG & COMPANY, New York, N. Y.
8—ROSS LABORATORIES, Columbus, Ohio
84—ROWELL LABORATORIES, INC., Baudette, Minn.
67—SANDOZ PHARMACEUTICALS, Hanover, N. J.
63—W. B. SAUNDERS COMPANY, Philadelphia, Pa.
11–21—SCHERING CORPORATION, Union, N. J.
74—G. D. SEARLE & COMPANY, Chicago, Ill.
59—SEEFURTH–McGIVERAN CORPORATION, Milwaukee
60–61—SICKROOM SERVICE, Milwaukee
58—SMITH KLINE & FRENCH LABORATORIES, Philadelphia, Pa.
51—SMITH, MILLER & PATCH, INC., New York, N. Y.
94—THE STUART COMPANY, Pasadena, Calif.
40—E. R. SQUIBB & SONS, New York, N. Y.
89—THE UPJOHN COMPANY, Kalamazoo, Mich.
7—USV PHARMACEUTICAL CORPORATION, New York, N. Y.
77—WALLACE PHARMACEUTICALS, Cranbury, N. J.
75—WARNER–CHILCOTT LABORATORIES, Morris Plains, N. J.
39—WARREN–TEED PHARMACEUTICALS, INC., Columbus, Ohio
76—WINTHROP LABORATORIES, New York, N. Y.
57—WISCONSIN 7-UP BOTTLERS ASSOCIATION, Watertown
47–48—WISCONSIN PHYSICIANS SERVICE, Madison

MANUAL ON ALCOHOLISM

Public policy is coming around to the view that alcoholism is not a crime, not a reflection of moral turpitude, not the mark or the shiftless, but an illness.

The change in attitudes is reflected in new legislation, court rulings, and increasing awareness of alcoholism's enormous social and economic costs.

A new Manual on Alcoholism, published by the American Medical Association, comes at a time when practical medical guidelines are needed in dealing with this problem.

In 87 pages, the AMA's new manual defines alcoholism and sets out its causes. It describes the metabolism and pharmacology of alcohol, and offers suggestions on diagnosis and the physical, psychological, and sociological aspects of treatment.

In plain language, it tells what an alcoholic is and is not, and what physicians can do to help him.

The manual is available from the Order Handling Unit, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610. Prices are 50 cents a copy in the U.S., its possessions, Mexico, and Canada (40 cents a copy for medical students, interns and residents in those countries), and 60 cents in all other countries.

the wisconsin medical journal

VOLUME 67/NUMBER 4 APRIL 1968

Considerations in the Preoperative Evaluation of the Major Organ Systems

By JOHN T. GOSWITZ, M.D., Manitowoc, Wisconsin

■ AS IMPRESSIVE AS the continuous advance of medical science has been, organ transplantation and artificial organ systems notwithstanding, a review of some of the fundamental principles which are of importance in the preoperative evaluation of the major organ systems is now and then necessary. The purpose of this paper is to outline briefly the important preoperative considerations which can help to make the surgical procedure and the postoperative convalescence as smooth and uneventful as possible.

Metabolic–Endocrine System

The crux of the metabolic care of the preoperative patient lies on the hypothalamic-pituitary-adrenal axis. The energy which must be produced so that wounds will be healed, antibodies will be produced, phagocytosis will occur, hemoglobin will be synthesized, lean tissue will be replaced, and fat will be gained is all ultimately dependent on this endocrine axis. This integrated system of endocrine glands must be brought into normal balance in order that the organism will survive the trauma of surgery and respond to the metabolic demands of the body in the postoperative period.[1]

Tests for adrenal function include: adrenal response to ACTH, blood steroids, eosinophil count, and urinary 17-hydroxy- and 17-ketosteroid excretion.[2] Cortisone must be supplemented in any patient who has been on cortisone therapy within three months prior to surgery.[3] The usual steroid regimen is 300 mg of cortisone in divided doses in the 24-hour period before and during which major surgery is performed. This dose can be reduced or increased depending upon the amount of steroid and the length of time the patient has been on therapy. The means for rapid intravenous supplementation of steroid should always be available.

Any pituitary or thyroid dysfunction must be evaluated by appropriate laboratory studies and subsequently brought into balance. Thyroid studies should include: protein-bound iodine, triiodothyronine, radioactive-iodine uptake, conversion ratio, and radioactive scan. Pituitary imbalance is manifested predominantly as adrenal insufficiency with secondary thyroid and gonad dysfunction.

The diabetic patient presents a complex problem which is often too casually considered. Besides the diabetic problems of neuropathy, nephropathy, and retinopathy, diabetics have an increased incidence of genitourinary disorders, coronary artery disease, gallbladder disease, and peripheral vascular disease. The tolbutamides and phenformin compounds should be continued to the day of surgery. For patients using the insulin agents, the insulin requirements can be supplied by one of two methods. The first method uses one-third to one-half the usual daily dose on the day of surgery. This suffices for short cases or minor surgery. The second method uses regular insulin in a dosage determined by urine test color change every six to eight hours. For brittle diabetics and long procedures, this second method is

From the Park Medical Center.
Reprint requests to: John T. Goswitz, M.D., 601 North Eighth St., Manitowoc, Wis. 54220.

safer and allows for better control of the patient in the early postoperative period.[4]

Malnutrition is as much a problem as obesity in the surgical patient. Obesity can increase the risk at the operating table, and if possible, time should be taken for weight reduction. However, the patient must be guided in this weight reduction with simple instructions and with a reasonable anticipated goal of weight loss.

The basic caloric requirement per day is 25 calories/Kg or ten times the ideal weight. A simple formula for ideal weight calculation used by the Metropolitan Life Insurance Company consists of a base weight of 112 pounds for women and 120 pounds for men. The base height is five feet. For each inch over five feet, add four pounds to the base weight. A range of ten pounds is allowed above or below the calculated ideal weight. This calculation estimates quickly the present nutritional status of the patient.[5]

Nutritional deficits and weight loss are often a byproduct of the disease process of the patient. Check for protein deficits with serum protein and electrophoretic measurements, and measure blood volume deficits with radio-iodinated human serum albumin (RISA). Generally, one can estimate a 50 ml blood volume deficit for each one pound of recent weight lost. Red-cell mass which is as important as total blood volume normally measures 40 ml/Kg in the young male. If the hematocrit level of the patient does not coincide with calculated red-cell mass, packed cell transfusions may be indicated. If whole blood, packed cell, plasma, or human albumin transfusions are indicated, they should always be given, if possible, over several days and at the time of the day which will not interfere with the normal rest of the patient.

The ambulatory patient is always better nutritionally than the patient on bed rest. It has been shown that bed rest leads to impaired erythropoiesis and loss of red-cell mass and plasma volume.[6] The restriction of physical activity impairs almost every organ system, and complete muscle inactivity causes a 3% loss of strength daily.[7] Physical activity must be encouraged during the preoperative period.

Cardiorespiratory System

In order to establish a baseline, electrocardiograms should be obtained routinely on all patients over 35 years of age, and multiple blood pressure readings should be recorded on the chart. Orthopnea, decreased exercise tolerance, ankle edema not of nutritional origin, angina, and a coronary occlusion within three months contraindicate strictly elective procedures.

Patients with coronary artery disease have a morbidity and mortality risk which is two to three times that of the total population having surgery. The age of the patient, type of procedure, and length of anesthesia must be considered in these patients, but these factors are of less importance than the clinical manifestations of their heart disease and the presence or absence of complications of their heart disease.[8]

The hypertensive patient is no risk per se. The antihypertensive agent should be continued up to the time of surgery in severe cases. Mild or moderate hypertensives may discontinue the drug if desired. Generally, it is hazardous to stop the drug and better physiologically to continue it. The rauwolfia compounds, guanethidine, and all the ganglionic blocking drugs respond to vasopressors should hypotension occur postoperatively.[9]

In the peripheral vascular examination, the presence of old phlebitis or varicosities should be noted. The postoperative use of elastic stockings in these patients will aid venous return and reduce the incidence of pulmonary embolism.[10] The venogram has proved invaluable in evaluating the deep system of veins in patients with varicose ulcers.[11] Selective catheter angiography has made possible the minute evaluation of the arterial trees into any organ or body segment.

The chest x-ray film is taken routinely to determine heart size and the appearance of the lung fields. A chronic wet cough that is productive indicates chronic bronchitis which can lead to postoperative atelectasis. Bronchial cleansing is best accomplished by warning the patient to stop smoking and with the use of steam inhalations, mucolytic agents, bronchodilators in aerosols, and antibiotics.[12] Patients with obstructive pulmonary disease are poor general anesthetic risks if the first second expiratory volume is below 65% of total vital capacity. Patients with restrictive disease are considered good general anesthetic risks if their vital capacity is 75% of normal, fair risks if their vital capacity is 40% to 70% of normal, and poor risks if be-

low 40%. If blood gas studies are indicated, an arterial oxygen tension below 65 mm Hg or carbon dioxide tension above 45 mm Hg classifies the patient as a poor general anesthetic risk.[13] Special studies include: bronchography, bronchoscopy, and mediastinal biopsy.[14]

Genitourinary System

If urinary retention is suggested, either by history or prostatic size, bladder residual can be determined with a small catheter immediately after voiding. Thus, severe urinary retention postoperatively may be prevented. Any suspicious prostatic nodule should be followed with a serum acid phosphatase, pelvic x-ray examination, and biopsy.

Intravenous pyelography has provided a standard means for diagnosing renal diseases and as a guide for evaluating renal function. Specific renal function tests should include those that reflect the filtering, secreting, and reabsorbing powers of the kidney. Serum creatinine is better than the blood urea nitrogen as a screen for glomerular filtration; phenolsulfonphthalein excretion tests the secretory powers of the tubules and it is the best single quantitative renal test; in the first 15 minutes, at least 25% of the dye should be secreted.[15] The 12 to 18 hour concentration test evaluates the reabsorptive functions of the tubules. A patient who fasts this length of time should have a urine specific gravity of 1.018 or higher. Further studies include: radioactive renogram, renal scan, split function studies, and selective angiography.

Patients with chronic renal disease require considerable preoperative study. Congestive failure must be corrected with digitalis and diuretics. Any anemia is best treated with packed red cells up to a hematocrit reading of 35%. Hyperkalemia can be reduced with sodium bicarbonate, glucose-insulin combinations, or oral cation exchange resins. Peritoneal dialysis may even be necessary. Metabolic acidosis will respond to bicarbonate either orally or intravenously. Hypertension can be reduced with antihypertensive agents and infection alleviated with antibiotics.[16]

Gastrointestinal System

The complete gastrointestinal x-ray study, including esophagogram, oral or intravenous cholescystogram, upper GI, barium enema, and small bowel series, has provided a ready means of diagnosis for most abdominal diseases. The liver and pancreas still provide the most difficult diagnostic problems. History, physical examination, serum enzymes, intestinal enzymes, absorption studies, negative x-ray shadows, and a high degree of suspicion are the principal methods of determining pancreatic diseases.

Differentiating liver diseases has revolved around the interpretation of the liver function studies. The principal studies accepted at present for screening liver function are: serum bilirubin, alkaline phosphatase, serum glutamic oxaloacetic transaminase and serum glutamic pyruvic transaminase, serum albumin and protein electrophoresis, and serum prothrombin time. The direct bilirubin and alkaline phosphatase are elevated the highest in obstructive jaundice. The transaminases ultimately depend upon functioning liver tissue and will rise if cell destruction occurs. Serum albumin and electrophoretic studies determine the ability of the liver to make albumin and can detect occult chronic liver disease. A value below 3.2 gm/100 ml indicates severe liver cell damage. The serum prothrombin time measures the manufacture of prothrombin from vitamin K and can be used as a screening test or as a test of cell recuperation. The bromsulphalein test has lost favor as allergic reactions have been reported, and it provides no additional information other than that which can be obtained by the above tests.[17] The liver scan is not yet accurate in determining liver masses, although strides are being taken in that direction.[18] All of these liver tests must be correlated with the clinical state of the patient. None should be removed from that context.

The routine proctosigmoidoscopy is invaluable and demonstrates the numerous rectal lesions which must be directly observed to be appreciated. These lesions include: fissures, hemorrhoids, polyps, and of course, carcinomas. The American Cancer Society has shown that only 13% of colon cancers are palpable per rectum and that 7 out of 8 asymptomatic cancers will be missed if sigmoidoscopy is not performed.

The controversy about the use of antibiotics in bowel preparations has not been resolved. Results have been good using only purges and enemas.[19] Selective angiography has helped to define and diagnose intestinal

angina and has been used to locate sources of gastrointestinal hemorrhage.[20]

Summary

Some considerations in the preoperative evaluation of the major organ systems are presented. The systems include the metabolic-endocrine, the cardiorespiratory, the gastrointestinal, and the genitourinary. The object of all of these studies is to provide a safe surgical procedure and a smooth postoperative course.

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ELECTRONIC MEDICAL DESIGN: TINY FLAWS CAN KILL

The Sept. 1, 1967, issue of *Electronic Design* carried an article entitled "The tiny flaws in medical design can kill." The subheading was "Errant currents from faulty electronic equipment are reported imperiling patients in certain cases." The author, Ronald Gechman, went on to report that a seemingly harmless voltage of 20 millivolts can kill a hospital patient under certain conditions. Moreover such a current may be generated by poorly designed electronic equipment. Thus far there have been no federal, state or local standards to regulate the design, construction, and electrical safety of equipment used in a hospital room or doctor's office, the author states.

Two major flaws in equipment are turning up, according to the critics, as medical electronics, still in its infancy, reaches out towards growing markets. These are faulty components in instrumentation or monitoring devices and wiring systems that do not provide maximum protection for a patient.

Doctor Paul Stanley, an engineering professor at Purdue University, says that physicians are well aware that small electric currents applied to the body can be fatal, but they are not fully aware that malfunctioning hospital instruments can produce these voltages. A number of studies indicate that ventricular fibrillation is responsible for the majority of deaths from electrical shock, he reports. At one midwest hospital, according to Doctor Stanley, 40 to 50 patients were shocked over a few months in 1965, owing to a design error in an electromechanical dye injector. Parts of the injector were anodized and while this effectively insulated the parts and caused a high resistance path to ground, the patients were grounded through other instruments. Since the patients were a better ground than the dye injector, current from the injector through the patients produced severe shock. Similar cases were reported that same year by the University of Wisconsin where one patient died and six others were severely shocked by the same dye injector.

Doctor Stanley noted errors in design in a heart–lung machine, defibrillators that produced excessive shock energies, equipment with chattering relays that produced high-voltage leakage currents and pacemakers that were sensitive to pulses on the power line. He also cited an instance where a cardiogram was being taken and the technician received a shock every time she attempted to attach the leads to the patient. The problem was traced to a bed lamp frame that was shorted and the lamp was touching the bed frame and so was the patient's arm. Since the cardiogram was routed through a three-prong plug and the lamp was not, the full ac line voltage, 117 volts, was shooting through both the patient and the technician.

A problem of repair arises when the equipment is too large to be sent back to the company and the hospital typically must pay $150 a day for the company to send out an engineer to repair it. Another problem is that many physicians and hospitals cannot agree among themselves on an acceptable design approach for a new medical instrument. This causes confusion among the companies trying to develop the new instruments.—V. S. Falk, M.D., Edgerton

Multiple Endocrine Adenomatosis Presenting As Cushing's Syndrome and Concurrent Hyperparathyroidism with Massive Gastric Hemorrhage

(Case Report with ACTH, Parathyroid Hormone, and Gastrin Assays)

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■ IN 1953, UNDERDAHL REVIEWED 15 patients with various combinations of endocrine adenomas and presented 8 new cases.[1] The description of the multiple endocrine adenoma-peptic ulcer complex as a familial occurrence has been documented adequately in several recent reviews.[2-4] The parathyroid, pancreatic islets, and pituitary glands are most often involved. Tumors of the islet cells have been the most common, occurring in 75% or more of patients. Parathyroid adenomas are the next most frequent, occurring in 30% of those reviewed and reported by Danowski et al in 1962.[2]

There are numerous examples of adrenocortical adenomas, hyperplasia or nodularity, described as part of the syndrome, but the association of clinical signs of adrenal hyperfunction is rare.[1-5] In 1939, Rossier and Dressler reported an instance of Cushing's syndrome in a patient whose family had multiple endocrine adenomas.[6] Schmid et al in 1961 redescribed this family, and the patient with Cushing's syndrome had been diagnosed subsequently as having hyperparathyroidism.[6,7] Raker, Henneman and Graf have reported two patients with simultaneously occurring Cushing's syndrome and primary hyperparathyroidism without other evidence of endocrine adenomas.[8]

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This report describes a patient presenting with severe bone disease and a full blown clinical picture of Cushing's syndrome. The diagnosis of hyperparathyroidism was initially suspected because of hypophosphatemia with minimal hypercalcemia and was subsequently confirmed at surgery. An asymptomatic pancreatic adenoma was also found at the time of adrenal surgery. Recurrent massive gastrointestinal hemorrhage resulted in his demise.

Case Report

This 32-year-old white man, a bank worker, was found to be hypertensive in November 1963 (160/100 mm Hg) and had a urinary tract infection at that time. A 15-lb weight gain and fatigue had been noted. He did not return for further evaluation.

He fell early in 1964 and fractured two ribs. Six months later he fell again and refractured the ribs. In August of 1964, he complained of pain in the right hip and severe sacral myalgia. He received several injections of 1% lidocaine (Xylocaine) and methylprednisolone acetate (Depo-Medrol) without prolonged benefit. His orthopedic surgeon then advised medical evaluation.

When seen in April 1965, the patient's chief complaint was low back pain which prevented normal flexion at the waist. Lower leg weakness of six months duration was also present. A gradual weight gain of 35 lb had occurred over a ten-year period. Facial plethora, abdominal stria,and nocturia times 2 had been noted for six months. Review of systems was not otherwise remarkable. The family history was negative for diabetes, bone disease and ulcer symptoms.

The patient was hospitalized at a Milwaukee hospital for evaluation of hypertension and possible Cushing's syndrome. Positive physical findings included obesity (centrifugal and centripetal), marked plethora of the face and neck, roundness of the face, and slight "buffalo hump." Pale red–purple stria were present bilaterally over the lower abdomen and inguinal regions. The remainder of the skin was normal. The blood pressure was 180/120 mm Hg in

Fig. 1—Depicts the moon facies, truncal obesity, and abdominal stria consistent with Cushing's syndrome.

Fig. 2—Skull x-ray film taken in 1948 at the time of a non-complicated minor head injury demonstrates a normal sella with well-defined posterior and inferior clinoids.

Fig. 3—Skull x-ray film taken in 1965 depicts the generalized osteoporosis with faintly outlined anterior and posterior clinoids. No erosion or ballooning of the sella is present.

both arms and peripheral pulses were all normal. Figure 1 demonstrates the cushingoid facies and body habitus with abdominal stria.

The hemoglobin was 12 gm/100 ml, and the hematocrit reading was 38%. The white blood cell count was 8,800/cu mm with a differential count of 75 neutrophils, 21 lymphocytes, and 4 monocytes. The urine was alkaline with a specific gravity of 1.011. No albumin or sugar was present. The urinalysis showed 7 to 10 white blood cells per high-power field. Fasting blood sugars were 174 mg/100 ml and 162 mg/100 ml, and the blood urea nitrogen was 20 mg/100 ml. The serum creatinine was 1.4 mg/100 ml, and uric acid 5.3 mg/100 ml. The total proteins showed an albumin of 4.2, and a globulin of 2.4 gm/100 ml. The serum sodium was 144, the potassium 4, and the chloride 105 mEq/liter. The carbon dioxide combining power was 32 mEq/liter and the pH 7.45. Three consecutive serum calciums were 9.8, 9.0, and 11 mg/100 ml. Corresponding phosphorus values were 2.4, 2.2, and 2.2 mg/100 ml. The alkaline phosphatase was 7.8 Bodansky units and the acid phosphatase 0.16. The serum glutamic oxaloacetic transaminase (SGOT) was 22. The creatinine clearance was 44 ml/minute. A 24-hour urine calcium was 260 mg while on a general diet, free of dairy products. Urinary steroid excretion studies are shown in Table 1 and indicated adrenocortical hyperfunction only partially suppressible by dexamethasone. The poor response to ACTH is not explained.

X-ray films showed multiple healed and healing rib fractures with marked generalized osteoporosis. The lung fields were clear. Skull x-ray films showed poor visualization of the clinoid processes because of demineralization, but the sella was not enlarged. Lamina dura were absent and hand x-ray films

TABLE 1—*Urinary steroid excretion studies with responses to dexamethasone suppression and ACTH*

Day	(May 1965)	17-Ketosteroid mg/24 hrs[9] (normal 7–20)	17-Ketogenic Steroids mg/24 hrs[10] (normal 8–20)	17-Hydroxycorticoids mg/24 hrs[11] (normal 4–12)	Volume
1	Control 1	25.2		13.7	
2	Control 2				
3	Dexamethasone 0.5 mg every 6 hrs	37	59		3600
4	Dexamethasone 0.5 mg every 6 hrs	26	30		3000
5	Dexamethasone 2 mg every 6 hrs	24	26		3490
6	Dexamethasone 2 mg every 6 hrs	15	33		3440
7	No medication	20	10		3100
8	ACTH (40 units in 500 ml. of normal saline iv over 8 hrs)	34	10		2900
	(June 1965)				
3	Dexamethasone 0.5 mg every 6 hrs	23	20.8	16	3680
4	Dexamethasone 0.5 mg every 6 hrs	18.6	18.1	12.7	2790

showed only generalized demineralization. Nephrocalcinosis was noted on the flat plate and poor renal concentration was noted in an intravenous pyelogram. Comparison of films taken seven months earlier showed a marked increase in pelvic structure demineralization. The patient was discharged, pending further study, with the diagnoses of Cushing's syndrome, secondary diabetes, hypertension, and possible hyperparathyroidism. Prior to surgery, a diabetic diet and 1.0 gm of tolbutamide daily had lowered the fasting blood sugar levels. Urine steroid studies in June 1965 again showed inadequate suppression from 0.5 mg of dexamethasone given every six hours. The serum calcium and phosphorus at this time were 11.4, 2.2; 10.6, 2.6; 11.6 and 2.7 mg/100 ml, respectively. The alkaline phosphatase remained normal at 7.9 Bodansky units.

On July 15, 1965, the patient underwent an exploratory laparotomy. Nodular hyperplasia of both adrenal glands was present and a bilateral total adrenalectomy was performed. A 1-cm reddish-purple adenoma was found on the superior surface of the pancreas 4 cm from the end of the tail and was removed by shelling out. Postoperatively the patient had several episodes of upper gastrointestinal bleeding but responded to transfusions and a medical regimen. No immediate postoperative increase in serum calcium levels occurred.

The gross pathologic examination indicated the left adrenal gland removed to be intact and measured 3.5 x 2.5 x 2 cm. Multiple yellow nodules averaging 2 mm in diameter were seen in the cortex and two larger nodules measured 9 x 13 x 13 mm and 8 x 10 x 10 mm. The right adrenal gland was removed piecemeal, but similar nodules were present. The pancreatic lesion was a benign islet cell adenoma. At discharge from the hospital, the blood pressure was 150/100 mm Hg and the fasting blood sugar

Fig. 4—X-ray film taken in August 1965 shows generalized osteopororis of rib architecture with several healing rib fractures.

Fig. 5—Sinusgram of the pancreatic drainage area taken in October 1965 shows the nephrocalcinosis present bilaterally. Also the size of the pancreatic sinus area is demonstrated.

TABLE 2—*Serum and urinary calcium and phosphorus studies with calculated intake after bilateral adrenalectomy (July 15, 1965), and gastric resection (August 12, 1965) while on cortisone acetate 12.5 mg three times daily*

DATE	INTAKE mg/24 hrs		URINE mg/24 hrs		SERUM mg/100 ml	
	Calcium	Phosphorus	Calcium	Phosphorus	Calcium	Phosphorus
9-2-66	1,115	1,232	235	224	13.6	3.3
9-3-66	955	1,192	303	232	13.4	4.0
9-4-66	305	427	314	256	13.8	3.7
					(Normal range 8.5–10.8)	(Normal range 2.5–4.5)

was 160 mg/100 ml. He was discharged on cortisone acetate, 12.5 mg three times daily.

Five days after discharge, while convalescing with his parents, the patient again noted tarry stools and became faint. He was admitted to a Marshfield hospital. Physical examination then revealed a blood pressure of 90/50 mm Hg. There were residual purplish-red stria over the lower abdomen. He had a well healed mid-abdominal scar. There were a few crackling rales in both lung bases posteriorly. Laboratory findings showed a hemoglobin of 7.4 gm/100 ml and a hematocrit of 22%. The white blood cell count was 12,400/cu mm with 77 neutrophils, 20 lymphocytes, and 3 monocytes. The platelet count was 100,000. The fasting blood sugar was 244 mg/100 ml. The blood urea nitrogen was 60 mg/100 ml. The serum sodium was 140 mEq/liter. The serum chloride was 111, and the potassium 4.9 mEq/liter. The CO_2 combining power was 18 mEq/liter. Control of the massive gastrointestinal bleeding without surgery was attempted. Eighteen units of blood were given over a four-day period. The hematemesis and passage of large amounts of blood by rectum continued. Therefore, on Aug. 12, 1965, a 70% gastrectomy and gastrojejunostomy was performed. Multiple ulcerated areas in the mucosa of the stomach were noted. A pancreatic cyst was found at the site of the previous benign adenoma. A total gastrectomy was not technically feasible. Postoperatively the patient required several further transfusions but he was gradually able to tolerate an ulcer regimen of low residue diet and magnesium–aluminum hydroxide (Maalox).

Table 2 summarizes serum calcium, phosphorus, and 24-hour urinary calcium and phosphorus values for a three-day period when he was eating and had no evidence of recurrent gastric hemorrhage. Cortisone acetate, 12.5 mg three times daily, was being administered. The unequivocally elevated calciums are particularly noted, indicating continued biochemical evidence of hyperparathyroidism. He was discharged Sept. 13, 1965.

The patient was readmitted Oct. 1, 1965, because of enlargement of the sinus tract in the area of the pancreatic cyst. The pancreatic abscess was drained to release a large amount of thick, purulent material. Saratoga tubes were placed both anteriorly and posteriorly, with suction and irrigation postoperatively. He was discharged on Nov. 8, 1965, with continued periodic irrigations in the pancreatic cyst area.

He was readmitted as an emergency on Nov. 9, 1965, because of bleeding in the area of the pancreatic cyst. On Nov. 10, 1965, a lumbar incision was made which showed marked bleeding from the pancreatic cyst area with erosion into the splenic artery. An abdominothoracic splenectomy was done. Postoperatively, the patient tolerated a low residue diet with antacids and continued maintenance cortisone therapy. Serum calciums periodically during this admission ranged from levels of 9.8 to 11.1 mg/100 ml. He was discharged on Dec. 10, 1965.

He was subsequently seen as an outpatient with continued irrigation of the pancreatic cyst drainage area. This gradually decreased in size and drainage subsided completely. Hemoglobin levels would decrease slowly after each hospitalization to levels of 7.8 gm/100 ml. Hematologic evaluation including studies for vitamin-B12, folic acid, and iron absorption showed no obvious deficiency. The hemoglobin gradually came to within normal limits with continued oral iron intake.

The patient was rehospitalized on the psychiatric service on Mar. 30, 1966, because of a profound depressive reaction. Physical findings showed a blood pressure of 120/90 mm Hg. The pulse was 96 per minute and regular. Stria over the abdomen were still visible but no longer purplish. Facial features and body habitus had gradually changed to a noncushingoid appearance. The patient refused photographs to document this. The right posterior subcostal area showed healing of the previous drainage site.

Serum calciums as an outpatient over the previous several months had been between 11.6 to 12 mg/100 ml. The patient was continued on cortisone acetate therapy, 12.5 mg three times daily.

On April 27, 1966, parathyroid surgery was performed. A 1 x 5 x 3-cm tumor mass lateral to the left lateral lobe of the thyroid and entwined with the inferior thyroid artery and recurrent laryngeal nerve was found. This was excised. A 1-cm firm tumor mass below the inferior pole of the right lateral lobe of the thyroid was also excised. Microscopic sections showed both of these to be consistent with parathyroid tissue showing hyperplasia of principally chief cells. The serum calcium postoperatively ranged from 9.4 to 10.6 mg/100 ml. A

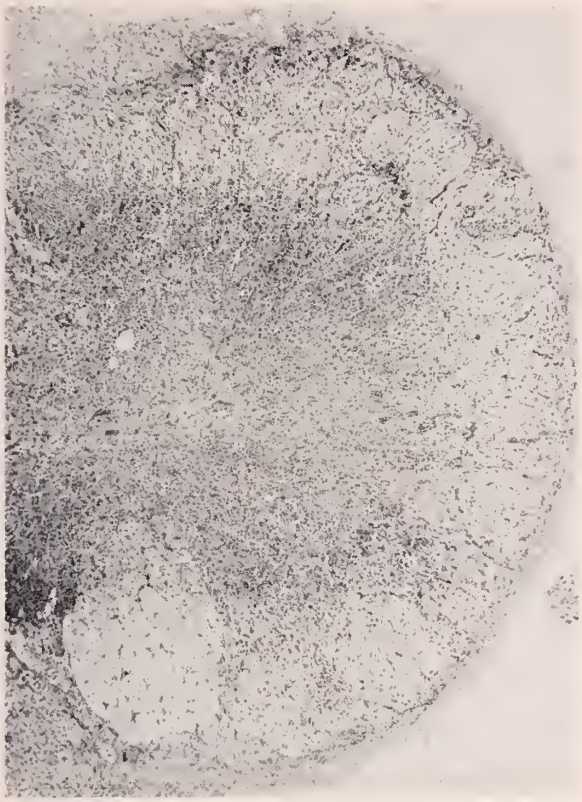

Fig. 6—The section through the right adrenal shows marked thickening of the zona glomerulosa. The individual cells are slightly larger than normal. The cytoplasm is clear, with small central nuclei. This change is seen diffusely (in multiple sections) of both adrenals consistent with diffuse bilateral adrenal hyperplasia.

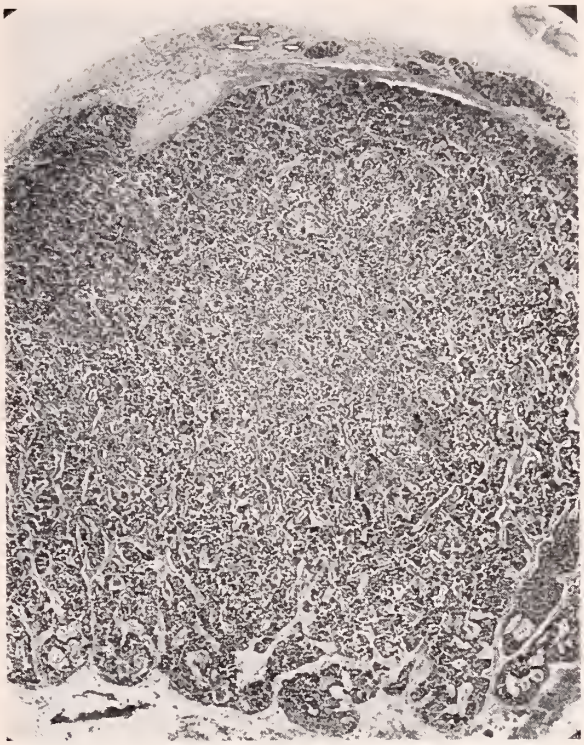

Fig. 7—This section of pancreatic tumor shows a nodular mass of islet cells, sharply circumscribed by a thin, fibro-connective tissue capsule. These are arranged in a reticular fashion separated by very scanty connective tissue which is very vascular. Within the capsule there are occasional pancreatic ducts lined by cuboidal cells and lobules of pancreatic acini.

total reabsorption of phosphorus study done according to the method of Bernstein, Yamahiro and Reynolds was 50% before and 62.5% after the parathyroid surgery.[12] The patient's severe depressive symptoms were not changed after surgery, and it was only after electroshock therapy was instituted that improvement ensued. This is described in greater detail in another publication.[13] He was discharged June 1, 1966.

The patient was lost to follow-up until Nov. 9, 1966, when he was brought in by his parents complaining of profound weakness. He had continued to take cortisone acetate with a daily total of 37.5 mg. He was extremely pale, lethargic, and refused to answer questions. His blood pressure was 88/44 mm Hg. The pulse was 104 beats per minute. Positive findings were limited to his pallor, a few residual abdominal stria, and scars from the previously described surgical procedures. The hemoglobin was 4.2 gm/100 ml, blood urea nitrogen (BUN) 20 mg/100 ml, and the initial blood sugar was 204 mg/100 ml. A total of six units of blood brought his hemoglobin to 10.6 gm/100 ml, and his vital signs stabilized. Additional cortisone in the form of intramuscular cortisone acetate and intravenous hydrocortisone sodium succinate (Solu-cortef) was administered. He was placed on oral antacids. An upper gastrointestinal x-ray study showed a marginal ulcer. The serum calcium was 9.9 mg/100 ml and the serum phosphorus 3.4 mg/100 ml. A 12-hour gastric volume measurement was 1100 ml from the remaining gastric remnant. Total acid was 77 degrees, with free acid of 38 degrees.

Gastrectomy was recommended, but refused by the patient and his parents. He was discharged Nov. 22, 1966, on his previous dosage of cortisone acetate and antacids.

TABLE 3—*ACTH and parathyroid hormone assay studies*

Date	ACTH* Immunoassay ($\mu\mu$g/ml)	Parathyroid Hormone Immunoassay* (μl-equiv Jo/ml)
2-14-66 (control) (Dexamethasone 5 mg every 6 hrs)	300	
2-16-66 (Dexamethasone 2 mg every 6 hrs)	300	
2-18-66	10	
4-26-66 (parathyroid surgery 4-27-66)		40
4-29-66		30
Normal fasting values	20	10-15

*Assays performed through the courtesy of Solomon A. Berson and Rosalyn S. Yalow, Radio-Isotope Service, Veterans Administration Hospital, Bronx, N. Y.

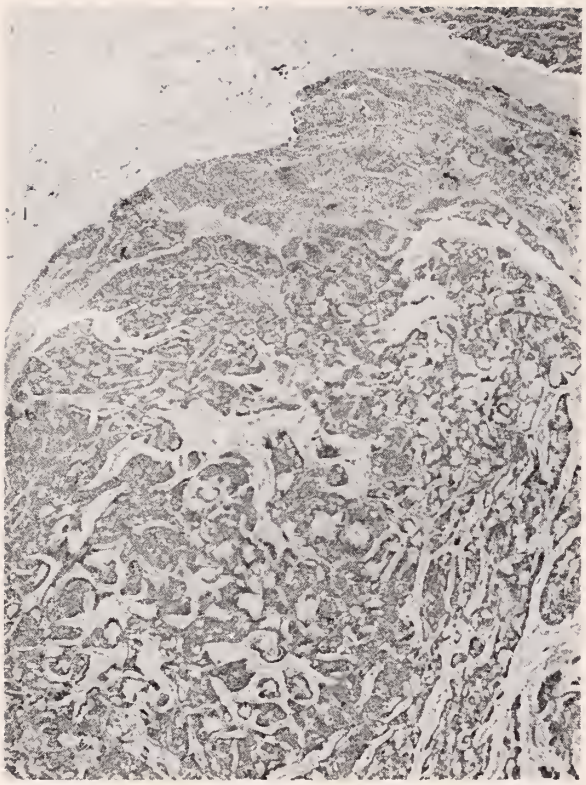

Fig. 8—The sections of parathyroid tissue show masses of chief cells which in numerous areas are forming small acini. The central lumen is filled with pink colloid material. Some of these are cystically dilated. Water-clear cells are practically absent in the sections. At the periphery of this section, there are occasional islands of deeply eosinophilic cells with central ovoid nuclei. In some areas the chief cells show markedly enlarged hyperchromatic nuclei. No mitoses are seen.

He was readmitted because of tarry stools on Nov. 25, 1966. His blood pressure was 70/40 mm Hg. The pulse was 120 beats per minute. There was no tenderness on abdominal examination. Reddish tarry stool was present in his rectum. His hemoglobin was 7.9 gm/100 ml. After stabilization of the blood pressure and hemoglobin with six units of blood, a total gastrectomy was done on Nov. 26. Hemorrhagic gastritis and an acute superficial gastric ulcer were found. Postoperatively he continued to pass small amounts of tarry stool. On Nov. 27, 1966, he developed hypotension, fever, and non-localized abdominal tenderness. Blood, plasma volume expanders, and antibiotics were administered along with intramuscular and intravenous hydrocortisone, but with no definite clinical response. He died on Nov. 29, 1966.

The patient's family refused consent for postmortem examination.

Comparison of skull x-ray films taken in 1948 at the time of mild head trauma (Fig 2) with those taken in 1965 (Fig 3) showed the development of osteoporosis and almost invisible clinoids. There was no actual deepening or enlargement of the sella. A chest x-ray film showed the healing rib fractures (Fig 4). A flat film of the abdomen (Fig 5) demonstrated bilateral nephrocalcinosis. The size of the sinus after the initial drainage of the pancreatic cyst is also seen.

Figure 6 shows the histologic architecture of the right adrenal gland which is consistent with diffuse hyperplasia. The microscopic section of the pancreatic adenoma removed at the time of bilateral adrenalectomy is depicted in Figure 7. Figure 8 shows the histologic findings of the parathyroid adenoma, demonstrating masses of chief cells, which form small acini in numerous areas.

Of particular interest are the ACTH, and parahormone assays done at various times during the course of this patient's illness as shown in Table 3.

Gastrin assay* on serum drawn Nov. 21, 1966, showed no assayable activity.

Discussion

Several aspects of both clinical and laboratory findings in our patient remain unexplained and are of interest.

The bone disease which led to the patient's examination could be explained by either the Cushing's syndrome or the hyperparathyroidism. The possible role of the adrenal corticoid excess in preventing marked hypercalcemia is also subject to speculation. It is likely that the combined renal and bone effects of excess hydrocortisone and parathyroid hormone contributed to the marked osteoporosis. Nephrocalcinosis and hypertension may also occur with either disorder. The marked generalized osteoporosis is well documented when the bone density in the 1948 and 1965 skull x-rays are compared. There is no sign of sellar enlargement or actual erosion of the clinoids to indicate pituitary tumor.

Interpretation of the urinary steroid data is difficult. Elevated baseline ketosteroids and hydroxycorticoids and inadequate suppression after 0.5 mg of dexamethasone every six hours confirms excess adrenocortical activity. The relative failure of suppression from large doses of dexamethasone, however, and the unexplained low values after ACTH stimulation, incorrectly suggested possible adrenal carcinoma.

Since Cushing's syndrome was more clearly documented, adrenal surgery was performed first. The finding of nodular hyperplasia suggests that the adrenal pathology was secondary to pituitary and/or hypothalamic dysfunction. The ACTH assays done in February 1966 (eight months after

* Performed through courtesy of Dr. Fred Moore, Chief Resident, Department of Surgery, University Hospital, Columbus, Ohio.

bilateral adrenal surgery while on maintenance therapy of cortisone acetate) would seem to confirm this. The finding of an islet-cell adenoma of the pancreas at the time of adrenal surgery was unexpected. The patient had no previous history of ulcer disease, unlike most patients with the Zollinger–Ellison syndrome.[14] There were no symptoms of hypoglycemia, although the latter may have been obscured by steroid induced diabetes. It would seem advisable, in view of this experience, to do gastric analyses on all patients with Cushing's disease, prior to adrenal exploration, to detect any evidence of increased gastric acidity, perhaps related to an islet-cell adenoma. The volume of 1100 ml of gastric juice measured with concomitant demonstration of a marginal ulcer in November 1966 would suggest increased humoral stimulation of gastrin-like activity. However, the gastrin assays did not corroborate this.

The results of parathyroid hormone assays and the TRP (total reabsorption of phosphorus) studied before and after removal of two parathyroid adenomata indicate continued apparent parathyroid hormone activity, in spite of repeated calcium levels in the normal range. Most probably, if our patient had lived, reexploration for hyperfunction of remaining parathyroid tissue would have become necessary.

The remote possibility of undiagnosed malignancy which was producing several types of peptides with end-organ manifestations also was not completely ruled out, since postmortem examination was not permitted.

Patients with Cushing's syndrome and associated hyperparathyroidism have been reported previously by Schmid[7] and Raker.[8] The presence of a pancreatic adenoma distinguishes our patient from those reported by Raker, et al. These authors correctly emphasized that hypercalcemia with Cushing's syndrome must be evaluated, as in an otherwise normal patient, and should not be attributed to adrenal hyperfunction per se.[8]

The familial aspects of various manifestations of the multiple adenoma complex have been emphasized.[3] To our knowledge, there is no such indication in this patient's parents or sister.

The increased availability of serum and tissue peptide hormone assays should be helpful in delineating more clearly the nature of the multiple endocrine adenoma-peptic ulcer complex.

Summary

A 33-year-old man with clinical and laboratory evidence of concurrent Cushing's syndrome and hyperparathyroidism is reported. Treatment by means of bilateral adrenalectomy with subsequent parathyroidectomy produced remission of cushingoid features and normal serum calcium levels. An asymptomatic islet-cell adenoma was also removed from the pancreas. Recurrent massive gastric hemorrhage caused his death. ACTH, parathyroid hormone and gastrin assays are reported.

ACKNOWLEDGMENT: The authors are indebted to Robert A. Frisch, M.D., who originally diagnosed and treated this patient's illness; to Sidney Johnson, M.D., and Donald T. Fullerton, M.D., who managed the terminal medical and psychiatric aspects of this patient's illness, and to Frederick Wenzel, Executive Director, Marshfield Clinic Foundation, for his help in the preparation of the manuscript.

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Recurrent Hydatidiform Mole

Report of a case of four recurrences and a review of the literature

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■ THE OCCURRENCE of a hydatidiform mole is rare. It is even more infrequent for a patient to have more than one molar pregnancy. The purpose of this paper is to present a case report of a patient who has had four hydatidiform moles, one associated with a fetus, and to review the literature on these subjects.

Case Report

This 25-year-old, married, white woman has been seen at the University Hospitals since Apr. 14, 1964. The obstetrical history is summarized in Table 1. In 1957 the patient experienced severe nausea and vomiting and had an elevated blood pressure. At six months of gestation spontaneous labor began and she delivered a one-pound, nine-ounce infant who lived only 10 hours. During the next six months the patient gained 100 pounds, developed hirsutism, and was started on thyroid medication.

The second pregnancy occurred in 1961 and was associated with an elevated blood pressure, albuminuria, and generalized edema. In December 1961, at five months of gestation, the patient's uterus was term-size. She began spontaneous labor and delivered a hydatidiform mole. Vaginal bleeding persisted in the postpartum period. A dilatation and curettage was performed in February 1962 and this showed molar tissue. A review of the microscopic sections showed this to be benign. In September 1962 a diagnosis of acute appendicitis was made. At laparotomy an appendectomy and bilateral ovarian wedge resection were performed. The microscopic sections showed a normal appendix and ovarian follicular cysts.

The third pregnancy was in 1963 and the patient was again hospitalized at five months of gestation for vaginal bleeding. In June 1963 at seven months of gestation the bleeding recurred and a diagnosis of placenta previa was made. A hysterotomy was performed and another molar pregnancy was found associated with a stillborn fetus. The microscopic sections showed this to be a benign mole. In October 1963 another D and C was performed and this revealed only secretory endometrium.

In December 1963 the patient experienced another episode of right lower quadrant abdominal pain following her menses. Another exploratory laparotomy was performed demonstrating an enlarged uterus and normal ovaries. No further surgery was carried out.

TABLE 1—*Summary of the previous pregnancies in this subject with recurrent hydatidiform molar pregnancies.*

Pregnancy Number	Date	Outcome
1	1957	Infant: 1 pound 9 ounce, died
2	Dec. 1961	Hydatidiform mole
3	June 1963	Hydatidiform mole and stillborn infant
4	July 1964	Hydatidiform mole
5	April 1966	Hydatidiform mole

The patient was referred to the University of Minnesota Hospitals on Apr. 14, 1964. Her last menstrual period had been December 13, 1963. On admission the physical examination showed the uterus to be enlarged to 23 weeks gestational size. No fetal heart tones were audible. There was bilateral pretibial and ankle edema. The cervix was probed to 3 inches without resistance. A urine pregnancy test was positive. A bio-assay for urinary chorionic gonadotropin showed between 1600 and 6400 I.U. per liter. The other routine laboratory studies including a chest x-ray film were normal. The patient began recording her basal body temperatures at this time and they were low and monophasic. She was discharged on April 18 and seen again on May 6. There was no bleeding and no fetal heart tones could be heard. An abdominal x-ray film on May 27 did not demonstrate fetal bones. On June 12 the patient began having vaginal bleeding. The cervix was then probed to 4 inches without resistance. The patient was readmitted to the hospital on July 4. A repeat fetogram showed some growth of the uterus but the fetal skeleton could not be seen. A failed amniocentesis was attempted. The uterine probe was passed to 11 inches without resistance. On July 30 labor was induced with oxytocin (Pitocin) intravenously and she delivered a 775 gm hydatidiform mole measuring 18 x 13 x 7 cm. A uterine curettage of the placental site was performed and this showed only placenta and decidua without evidence of malignancy. Two units of blood were

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administered. The highest blood pressure recorded prior to delivery was 150/105 mm Hg and all of the postpartum blood pressures were normal. The laboratory studies included normal skull and chest x-ray films, protein-bound iodine, glucose tolerance test and serum electrolytes. The 24-hour urinary 17-ketosteroid excretion was 10.6 mg and the 17-hydroxycorticosteroid was 4.2 mg. The patient was discharged on Aug. 4, 1964.

The patient recorded basal body temperatures and she ovulated in October 1964. She continued to have ovulatory cycles with negative pregnancy tests.

On Feb. 14, 1966, the patient was readmitted during her fifth pregnancy. There had been vaginal bleeding and cramping since her last menstrual period on Dec. 1, 1965. The examination showed the uterus to be enlarged to 14 weeks gestational size. The urine pregnancy tests were positive. After the bleeding and cramping stopped, she was discharged and seen every two weeks in the outpatient clinic. Her basal body temperatures remained elevated. On Apr. 12, 1966, she was readmitted with uterine cramping and vaginal bleeding. She spontaneously passed molar tissue and an intravenous oxytocin stimulation of the uterus was performed. A 275 gm hydatidiform mole was expelled which measured 15 x 11 x 19 cm. The placenta site was curetted and benign molar tissue was obtained. The patient's blood pressure was elevated only once during this entire pregnancy. A chromosome analysis was done on the patient's blood and this showed a normal XX karyotype. A mild endometritis which developed postpartum responded to antibiotics. She was discharged on Apr. 20, 1966. The patient has been followed in the Outpatient clinic since that time and has had negative pregnancy tests and negative chest x-ray films. The histologic sections from each molar pregnancy have been reviewed by Dr. J. L. McKelvey.

Discussion

The reported incidence of hydatidiform moles varies from 1 in 82 pregnancies in the Orient to 1 in 2500 pregnancies in the Western world.[1, 2] Recurrent hydatidiform moles are even more rare with a reported incidence of 1 in 75 molar pregnancies.[3] This low incidence is partially explained because many patients are treated with hysterectomy after their first molar pregnancy.

In 1912 Essen–Möller reviewed 12 cases of recurrent molar pregnancy.[4] In 1946 Chesley reviewed the literature and found only 39 proven cases of recurrent hydatidiform mole. He added one case of his own.[5] Several additional cases have subsequently been reported.[6–12] The majority of these cases have had only 2 molar pregnancies although as many as 18 recurrences have been reported.[5] Most of the patients have had successive repetitions of molar pregnancies rather than the interspersion of molar pregnancies and normal pregnancies. The problem in reviewing these cases is to be sure that one was reporting a new pregnancy rather than the growth of a persistent mole. In the present case there was evidence of the absence of molar tissue between each pregnancy.

The etiology of a molar pregnancy is still unknown. Although the difference in incidence in different parts of the world suggests an environmental factor, the reported recurrences and also chromosome karyotype abnormalities lend weight to a genetic factor.[13] In the present case the chromosome analysis was normal and no etiology for the moles could be determined.

The associated complications with hydatidiform moles will at times aid in their diagnosis. Vaginal bleeding is the most common symptom. Hyperemesis is frequently seen and this is often more severe and protracted than in a normal pregnancy.[9, 12] The appearance of pre-eclampsia or eclampsia prior to the 24th week of gestation also may suggest the possibility of hydatidiform mole. This seems to be the more common with repeated moles.[5, 14] Ovarian cyst formation is also common.[2]

The clinical picture may suggest the diagnosis but proof is often difficult. Bromberg et al have suggested that the elevated levels of circulating fetal hemoglobin suggest a molar pregnancy.[15] The uterine "probe" test is also helpful. The final diagnosis, however, depends upon the passage of molar tissue. This causes problems in the clinical management of those patients with a history of a hydatidiform mole and a current early pregnancy. The newer methods of detecting the fetal heart should prove to be helpful to the diagnostician. Larks has detected the fetal electrocardiographic complexes by 11 weeks and Bishop has noted cardiac ultrasonic motion at 10 weeks of gestation.[16, 17] Although a fetus may be associated with a hydatidiform mole as in the current case, Beischer has reviewed this rare problem and finds only 93 instances reported.[18]

Finally, the physician must warn and follow the patient for the possibility of trophoblastic malignancy. There is a suggestion from the literature that the malignancy rate in recurrent moles is higher than in isolated moles.[5, 10, 19] Management then dictates close clinical following with the ancillary use of chest x-ray studies and gonadotropin determinations. Koga and Maeda have em-

phasized the usefulness of the basal body temperature in management of trophoblastic tumors.[20]

Summary

The report of a patient having four consecutive hydatidiform molar pregnancies is presented. One molar pregnancy was also associated with a fetus. The literature concerning these problems is reviewed.

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INTRAMURAL DUODENAL HEMATOMA IN CHILDREN

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Amer J Dis Child 115:37–42 (Jan) 1968

Blunt trauma to the upper abdomen may result in traumatic intramural duodenal hematoma producing the findings of high small intestinal obstruction. Luminal occlusion of the duodenum by an enlarging hematoma in the gut wall due to disruption of the subserosal or submucosal vessels is the mechanism of occurrence of the pathologic process. The diagnosis is confirmed by upper gastrointestinal roentgenologic studies demonstrating an intramural duodenal mass with a coil-spring mucosal pattern overlying the mass. Three instances of intramural duodenal hematoma have been encountered at Milwaukee Children's Hospital. One patient was treated surgically without preceding upper gastrointestinal studies; the other two, having been diagnosed by characteristic roentgen findings on upper gastrointestinal studies during the acute stage, were treated medically with disappearance of the obstructive process on follow-up contrast studies.

A trivial blow to the abdomen in an unguarded moment is probably sufficient to cause enough disruption of subserosal or submucosal vessels to produce the hematoma in the wall of the duodenum. The pathogenesis of this occurrence is not clearly understood.

The plain film findings in all three cases demonstrated distention of the stomach and a paucity of gas in the intestinal tract, suggestive of high intestinal obstruction. Subsequent contrast studies of the upper gastrointestinal tract reveal an obstructing intramural mass which is relatively smooth and well demarcated. It demonstrated a characteristic coil-spring appearance. As the obstruction subsided over a period of days, the findings became less marked with disappearance of the coil-spring effect and replacement of this effect by widening of the mucosal folds ("picket fence") due to residual edema.

The radiographic differential diagnosis includes intussusception, which may give some difficulty in diagnosis; however, the lack of shortening of the duodenum and the relative eccentricity of the mass should tend to exclude this diagnosis. The length of the mass, the coil-spring effect, and the prominence of the edematous valvulae conniventes exclude neoplasm. Regression and final disappearance of the mass is confirmatory. Enlargement of the head of the pancreas due to a cyst or to pancreatitis widens the loop of the duodenum while an intramural duodenal hematoma impresses the convex curve without widening the concavity of the duodenal loop.

The occurrence of an intramural duodenal hematoma without complicating factors justifies conservative treatment with naso-gastric suction and intravenous fluids. Surgery should be reserved for those cases which develop (1) signs or symptoms of intraperitoneal hemorrhage, or ruptured viscus; (2) progressive obstruction without any sign of resolution; (3) where there is associated visceral injury; and finally, (4) if the medical management fails to improve the condition after reasonable trial. We suggest more conservative treatment for intramural duodenal hematoma and recommend that laparotomy be employed only if injury to other viscera is suspected, or when complications occur.

Doctor Babbitt is Director, Department of Radiology, Milwaukee Children's Hospital.

MEDICAL HISTORY FEATURE

PART I:

William Osler's Education

By JOHN H. GREIST, M.D., Madison, Wisconsin

IN APRIL 1913, when Sir William Osler, Regius Professor of Medicine at Oxford, journeyed to North America to deliver the Silliman Lectures at Yale, he agreed to preach a lay sermon to the undergraduates as well. He was 63 years old at the time and the title of his sermon was "A Way of Life." His opening words were "Fellow Students."[1]

This paper reviews some of the educational experiences of this remarkable physician and lifelong student and touches briefly on the reactions he came to have about medical education.

William Osler was born July 12, 1849, at Bond Head in Tecumseth County in a parsonage near the edge of the wilderness in Upper Canada where his father and mother, Featherstone and Ellen Osler, had come in 1837 to establish the church. Featherstone had gone to sea for several years before being elected a mathematical scholar at Cambridge and taking Holy Orders. Willie was the youngest boy and the last of nine children to survive childhood. Chief among the family's problems was the children's education. Harvey Cushing's Pulitzer Prize winning biography, *The Life of Sir William Osler*, from which much of the source material for this paper was obtained, puts it this way.[2]

> "At first a log school-house near by, where one of the neighbouring family of Gavillers taught the rudiments of the three R's, was all that the vicinity afforded. Then a Mrs. Hill started a school near Bradford some miles away, which the elder boys attended, and finally a school was opened in Bond Head by a Mr. Marling, to which in due course the children trudged."[3]

But the greatest part of their early education was "at their mother's knee and with the Bible as the main source of it."[4] Their father's library, as recalled by one of the sons, consisted largely of "solid and indestructible blocks of divinity of all kinds,"[5] as well as writings of Edward Osler, an uncle and naturalist-physician from Truro, Cornwall, and other books by Samuel Butler, John Bunyan, John Locke, and Lord Tennyson.

In 1857, the family moved to Dundas at the very western tip of Lake Ontario, where the community counted seven churches and a newspaper. For the next eight years, Willie attended the local grammar-school which was taught by two Irishmen and occupied quarters above a common school, a situation which lead to many minor antagonisms.

Doctor Greist was a Resident in Medicine, Veterans Administration Hospital, Madison; and has been a Resident in Psychiatry at the University of Wisconsin Medical School. The Senior Class voted Doctor Greist the best Resident Teacher of the 1966–1967 academic year.

A special aggravation was the common school's headmaster who developed a strong dislike for grammar-school boys. Even at this age, Osler "was particularly ingenious in evolving and perpetrating practical jokes of an elaborate and unusual sort,"[6] a pastime in which he indulged with lifelong enthusiasm.

> "Whether it was the flock of geese found one morning locked in the room of the common school, or the discovery on a Monday morning of a school without furniture, the desks and benches all having been unscrewed from the floor and laboriously hoisted up through a trap-door into the garret the Saturday afternoon before; or whether it was some disparaging remarks concerning the headmaster of the common-school shouted through a keyhole, . . ."[7]

Willie was expelled and was able to shout joyfully to his older sister as he rode home bareback on his father's horse, "Chattie, I've got the sack!"[8] Osler's timing was superb, for it was June and he had outgrown the intellectual confines of the Dundas school and his parents were thinking of a change anyway.

THUS in 1864 he followed his older brothers to Barrie, a grammar school whose principal, the Rev. W. F. Checkley, was a famous schoolmaster. Although a friend recalled that "Osler easily ranked first in the whole school"[9] and excelled in the Bible, the spirit of fun seemed almost to distinguish him more. Along with Ned Milburn, one of "Barrie's Bad Boys,"[10] he answered an advertisement in the local paper by an American farmer requesting a wife. The two dressed up as girls, Ned a blond, and Osler, with his olive skin, a brunette, and met the farmer at night in an ill-lighted railway station. The farmer chose the blond and left, promising to return in a month after fixing up his house for the bride.

Osler was also said to be a fine athlete with a lithe body and the "elastic swinging step of a boy which characterized him to his last days."[11] He won several prizes for track and field events, and played cricket and rugby when they were in season.

After one year at Barrie, he moved on to Weston, a preparatory school for Trinity College, Toronto. There he met two unusual men whose influence on him was profound. In the Reverend William Arthur Johnson, Osler found a real master who, as he put it, "knew nature and how to get boys interested in it."[12] Johnson was a ritualist in religious matters, but he had an unbounded curiosity for matters of the natural world and struggled hard to reconcile his religious beliefs with the facts of natural selection and evolution. Cushing describes Johnson as

> "an omnivorous naturalist, ranging widely with no attempt at specialization. Everything interested him, the structure of the hair of different animals from the caribou to the flying squirrel, the structure and growth of wood, the study of fossils and minerals, the finer anatomy of moths and butterflies and insects of every kind, some of which he unblushingly transferred from his own person or bed to the stage of the microscope; seeds and shells, ferns and mosses, bones and teeth. He was an amateur, it is true, and dabbled in many fields, but the flame nevertheless burned brightly, and he knew how to transmit it to others.[13]

Johnson kept a notebook, took the *Microscopical Journal* and had a library of five or six hundred volumes which, while chiefly ecclesiastical, was leavened with Lyell and Dana, Gray and Carpenter.

The other man who exerted a profound influence on Osler at this period was Dr. James Bovell, the school's medical director. Although in private practice in Toronto and a professor at the medical schools of both Trinity College and Toronto University, he spent some time each week with Reverend Johnson, in naturalistic pursuits. Throughout his life, in idle moments, few though they must have been, Osler would write over and over, "James Bovell, M.D., M.R.C.P." It was here, exposed to Johnson's library and his habit of keeping a notebook, that Osler began his first notebook. These foundations led him to say, years later, "The student practitioner requires at least three things with which to stimulate and maintain his education, a note-book, a library, and a quinquennial brain-dusting."[14]

His early notebook was well done, for he was able to draw upon it ten years later for descriptions in a paper on fresh-water polyzoa. In May and June of 1867, he tabulated and studied his collection of Diatomaciae and worked hard for a scholarship. He graduated at the head of his class and won a Dixon Prize Scholarship to Trinity College in Toronto where he went in the fall of 1867 with the expectation of entering the ministry. The summer before entering Trin-

ity was spent reading for the matriculation examinations at the lakeside home of Reverend Fletcher. After lessons were done, Osler and several other students would often "sit up till midnight watching under a microscope, borrowed from Dr. Bovell, the activities of fresh water algae."

BEFORE leaving Osler's schoolboy days, an episode of some fame merits recounting. Weston's headmaster, a martinet and pedagogue who taught classics, had engaged a housekeeper and her buxom daughter, both of whom the students disliked. As Cushing relates it,

> "The story can be found in the court records of the Toronto Globe for April 8–13, 1866, under the caption, 'School Row at Weston. Pupils Turned Outlaws. They Fumigate the Matron with Sulphur.' The assault was in revenge for a specified offence, the despised female the day before having upset a pail of slops on the stairs, which soused one of the boys. Hence, on the day in question, the coast being clear and at Osler's instigation, they barricaded 'the old girl' in her sittingroom, and made a paste of molasses, mustard and pepper, which they put on the schoolroom stove, so that the fumes rose to her room through the stovepipe hole. The prisoner first stuffed the hole with some clothes, which the boys pushed back with pointers. Being resourceful and to avoid suffocation, she sat on the register and screamed for help, while the boys poked at her from below as they had done to the clothes. Ultimately she was rescued by the Head Master, and the boys, as can be imagined, duly experienced the effects of the Walpole Hickory strips. But this did not satisfy the Matron, who demanded their arrest for assault and battery. Unable to get a warrant issued in Weston, she finally secured one in Toronto, so that the nine boys, including the Warden's two sons (Rev. Johnson's Boys), passed a few days in the Toronto jail, and were defended by the young Osler's elder brother, Featherston, before the magistrate in the county council-chamber, with the result of a reprimand and payment of a dollar and costs. At all events, they had effectually 'smoked the old girl out,' for she refused to stay longer at the school. 'It was an unfortunate affair,' wrote his mother on April 19th, 'that of all you boys being brought into public notice in such a disreputable manner, and although I do not think it was meant to be more than a mere school boy prank, such things often tell against a person long after, and I hear many say they think it will injure the reputation of the school.' With which mild reprimand his 'ever loving Mother' ended by enclosing two dollars and a postage stamp."[15]

At Trinity College, where Osler went intending to become a clergyman, he came closely and strongly under Doctor Bovell's influence. Bovell, a perennial peripatetic, was born in Barbadoes, first educated in England at Cambridge and then at Guy's Hospital where he was a dresser for Astley Cooper and was befriended by Bright and Addison, then studied at Edinburgh in pathology under Doctor Craigie, next in Glasgow where he took his first doctor's degree, and finally, in Dublin under Stokes and Graves.[16] Although he was assured a bright career in Britain, he returned home to Antigua to practice and then emigrated in 1848 to Toronto. Curiously, at the time Osler knew him, Bovell was in the process of changing from medicine to the church. In 1870, when Osler left for McGill and his clinical years, Bovell went to the West Indies, took Holy Orders and stayed until his death in 1880, the same year the Reverend Johnson died. After a year at Trinity in the Arts, Osler made his decision and switched to Toronto Medical School, a change which delighted Bovell. Osler spent much of his free time away from the classroom with Bovell, living in a room in his house, preparing specimens for him and accompanying him on his house calls; in fact, providing a measure of organization which the brilliant Bovell lacked. Bovell's library, containing volumes as broad and varied as their owner, continued Osler's general education. Fifty years later in the introduction to the Bibliotheca Osleriana (published at Oxford by the Clarendon Press in 1929, nine years after Osler's death), Osler recalled,

> "'Three years of association with Dr. Bovell were most helpful. Books and the man!—the best the human mind has afforded was on his shelves, and in him all that one could desire in a teacher —a clear head and a loving heart. Infected with the Aesculapian spirit he made me realize the truth of those memorable words in the Hippocratic oath, "I will honour as my father the man who teaches me the art".'"[17]

AND AGAIN, in 1903, in a "tribute of filial affection" on the occasion of the amalgamation of the Toronto and Trinity Medical Schools he remembered that:

> "'When in September 1870 Bovell wrote to me that he did not intend to return from the West Indies, I felt that I had lost a father and a friend; but in Palmer Howard, of Montreal, I

found a noble step-father, and to these two men, and to my first teacher, the Reverend W. A. Johnson, of Weston, I owe my success in life—if success means getting what you want and being satisfied with it.' "[18]

BUT Bovell was somewhat unsteady, and Osler observed "that in spite of his rich mental endowment there was, from attempting too many things, 'a want of dogged persistency of purpose without which a great work can scarcely be accomplished,' " and he adds, " 'It may be well for a physician to have pursuits outside his profession, but it is dangerous to let them become too absorbing.' "[19] Cushing summarizes the moment:

"It was just as well that Osler at this time was destined to come under the steadying influence of a less brilliant personality. Nevertheless, in spite of, or because of, Bovell, it is apparent that in this last year at Toronto Osler laid the foundations of what were to be his subsequent habits of life. The cornerstone of the foundation was work and the finding of this a pleasure."[20]

To be continued in next issue.

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PROLONGED SURVIVAL OF LYMPHOCYTES WITH CHROMOSOMAL DEFECTS IN CHILDREN TREATED WITH 1,3-BIS (2-CHLOROETHYL)-1-NITROSOUREA

EMMA K. HARROD, (Roswell Park Memorial Institute, Buffalo, New York), and JEAN A. CORTNER: *J. Nat. Cancer Inst.* 40:269–282 (Feb) 1968.

Chromosomal defects were observed in as many as 65% of the cultured circulating leukocytes of 6 children with acute leukemia and 2 with Ewing's sarcoma of the femur who were treated with 1,3-bis-(2-chloroethyl)-1-nitrosourea (BCNU), a lipid-soluble alkylating agent. These defects, which included breaks in chromatids and chromosomes and interchanges of chromatin between 2 or more chromosomes to form triradials, quadriradials, and other multibranched chromosomes, persisted for 1–11½ months after BCNU therapy. The other chemotherapeutic agents and previous diseases of these patients are unlikely to have produced these defects, since a similar group of control patients had no significant number of chromosomal defects in their cultured leukocytes. Identical defects were produced by *in vitro* BCNU treatment of cultured leukocytes from 2 normal adults. *In vitro* studies also showed that BCNU affects all chromosomes randomly; however, the effects do not appear immediately after treatment. These chromosomal defects were found only in cells presumed to be lymphocytes in spite of BCNU's lethal effect on many cell types. This specificity may be more apparent than real and secondary to known characteristics of lymphocytes and their response to phytohemagglutinin. Despite the large number of agents capable of damaging chromosomes, only irradiation and, recently, lysergic acid diethylamide have been reported to produce defects which persist for long periods following *in vivo* therapy.

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"Surgical Management of Axillary Burn Web," also by Dr. Boswick, 12 min.

"Radical Operation for Carcinoma of the Vulva During Pregnancy," Denis Cavanagh, M.D., F.A.C.O.G., professor and chairman, department of obstetrics and gynecology, St. Louis University School of Medicine, Henry E. Averett, M.D. and Allan G. W. McLeod, M.D., F.A.C.O.G., University of Miami School of Medicine, 15 min.

"Radical Vulvectomy with Posterior Extenteration," also by Dr. Cavanagh, with Manuel R. Comas, M.D. and Joseph A. Decenzo, M.D., F.A.C.O.G., 15 min.

"Full Thickness Skin Graft Repair of Urethral Strictures," P. C. Devine, M.D., C. E. Horton, M.D., C. J. Devine, Sr., M.D., C. J. Devine, Jr., M.D., H. H. Crawford, M.D., and J. E. Adamson, M.D., all in practice in Norfolk, Virginia, 25 min.

Requests for further information about the films or for showings can be directed either to Eaton's sales representatives or to the Eaton Medical Film Library, Eaton Laboratories, Norwich, New York 13815.

Therapeutic Dilemmas

No. 6 of a Series

Editor:

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COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

ACUTE NON-SPECIFIC BENIGN PERICARDITIS

Moderator: FRANCIS F. ROSENBAUM, M.D.

Participants: FRANCIS F. ROSENBAUM, M.D.
MARILYN MACKAY, M.D.
JOHN C. WEBER, M.D.
A. H. PEMBERTON, M.D.
GUENTHER POHLMANN, M.D.
GEORGE C. OWEN, M.D.

Dr. Francis F. Rosenbaum: The malady we are considering this morning more often presents problems in management than in diagnosis, although the actual patient upon whom the discussion will focus does exemplify the diagnostic angles of pericarditis of this type. Doctor Mackay will present the history.

Dr. Marilyn Mackay (Intern): This 57-year-old white man, an exuberant sales executive, has had four hospital admissions for chest pain. We know very little about the first of these, which occurred in California in August 1964, except that for the first 3 of the 18 hospital days he had chest pain. Subsequently he felt well, played golf and continued very actively at his work, which included a lot of traveling. Then, in February 1967, while in California again, he had an attack of chest pain, flew home and was admitted to this hospital on February 5. At this time there was gripping, substernal chest pain, which radiated into the throat and neck and persisted for the first 48 hours of hospitalization. It was worsened by alteration in position and by breathing. But he was discharged practically asymptomatic on February 16. Between this time and early May he did no traveling and attempted to reduce his work load somewhat as advised, but it is probable that he was nevertheless still working very hard. Then, when out in California once more, he began to feel unwell and had intermittent chest pain for about two and one-half weeks. This pain was not affected by exertion, but breathing and coughing accentuated it. He did not stop work during this time, but finally upon the insistance of his daughter he returned home and entered the hospital for the second time on May 9, 1967. During this admission he was free from chest pain, looked and felt well, and was discharged on May 20. But he returned one week later with a recurrence of the same symptoms. On this admission, May 27, he appeared much more ill than previously, and he had fever that persisted for four days. He was now very discouraged, but was discharged again on June 5 feeling much improved. He had lost 15 to 20 pounds in the preceding three or four months, but this appeared to be entirely related to a self-imposed reducing diet.

The medical history reveals operation for ruptured appendix at age 7 or 8; "nervous breakdown" in 1933; tonsillectomy and adenoidectomy in 1935; three operations at this hospital for recurring inguinal hernia; hemorrhoidectomy in 1952; rectal polypectomy in 1958; sebaceous cyst and papilloma of the skin removed in 1966; numerous treatments during the past 15 years for plantar warts, which always recurred.

The patient is a rather effusive man who looks his stated age and appears to be in overall good health. All physical findings are essentially normal. There is some increase in the anteroposterior chest diameter with adequate bilateral expansion. The apical beat is easily palpable in the fifth interspace just at the midclavicular line. At no time to my knowledge has anyone heard a pericardial rub in this man.

The laboratory findings during the three admissions are shown in Table 1. The white blood cell count has been moderately elevated

TABLE 1—*Laboratory findings during the three admissions*

Studies	Admission No. 1	Admission No. 2	Admission No. 3
WBC	14,775 9,000	12,000	13,000 12,000, 8,000, 10,000
NS			2
Segs.	53		78
Lymph.	28		18
Mono.	18		1
Baso.	1		1
Hb.	13.3	11.2	10.8 rep. 12.2
Hct.	40%	35%	32% 33%
ESR	51	124	120 110
Serum Protein Normal	6 gm↓alb.↑σ1 σ2		6.8 gm↓alb.↑σ1 σ2
VRDL, SGOT & LDH (x4) 2 hr. PP sugar		Liver	LE x 2, liver panel, Creatinine, ASO, latex

throughout, but the hemoglobin has fallen somewhat, the last determination, made two days after the immediately preceding one, being somewhat contradictory. On the other hand, the erythrocyte sedimentation rate has progressively increased; it was 51 on the first admission and over 100 on the succeeding ones. On the second admission an electrophoresis study was made. The total protein was down to 6 gm with a slight increase in alpha 1 and alpha 2 globulins; essentially the same findings were made on the third admission. Repeatedly on all three admissions there have been normal serum glutamic oxaloacetic transaminase and lactic dehydrogenase determinations. The liver panel, omitted on the first admission, was normal on the last two. All other findings also normal, as shown. On the second admission the blood serum was negative for psittacosis, Q fever, influenza A-1 and B, herpes simplex, primary atypical pneumonia, Eaton agent and adenovirus; a test for Coxsackie virus was not done. On the last admission the C-reactive protein was 1+. The x-ray and electrocardiographic (EKG) findings will be discussed by Doctors Weber and Rosenbaum.

A Physician: Did the patient's sedimentation rate return to normal between attacks?

Dr. Mackay: We do not have an adequate series of determinations from which to supply an answer to the question, but with the first admission to this hospital the sedimentation rate was 51, with the second it was 124, and with the third it was 120, and later 110. So we have never seen him with a normal sedimentation rate.

Dr. John C. Weber (Department of Roentgenology): The first of the four films (Fig 1) was taken during the first, or February, admission; the last three (Fig 2, 3, 4) during the later admissions, on May 9, 17, and 29, respectively. The first film was essentially negative except for calcific changes in the arch of the aorta. In the May 9 film (Fig 2) there is enlargement of the transverse cardiac dimension, congestive changes in both lung bases, and early pleural effusion bilaterally. In the May 17 film (Fig 3) there is close resemblance to the first film, consequent upon more than two weeks of hospitalization. Then in the final film (Fig 4) after the patient had been out of hospital for about 10 days, there is again cardiac enlargement in the transverse dimension with congestive changes and bilateral pleural effusion. These changes are *not* specific for pericarditis; in fact, they are more consistent with congestive heart failure of some sort. To be specific for pericarditis there would have to be cardiac enlargement *without* the congestive changes and pleural effusion. For diagnosis of pericarditis with films such as we have here one would need clinical findings compatible with the disease.

Dr. Rosenbaum: I saw this man on his first admission to this hospital and then again on his third admission. He was discouraged and unhappy this last time because his recurrent illnesses at short intervals were interfering with his business activities. On the first, or February, admission the primary EKG deviation from the normal comprised a very modest elevation of the RST segment, seen particularly in the standard leads. And he did *not* go on to develop T wave changes. On the second, or first May, admission there was none of the RST segment elevation but a very distinct inversion of the T waves in both the standard and the precordial leads. And this same T wave configuration characterized the admitting EKG when he came in the third and last time, one week after discharge from the second admission. However, in a matter of only a few days this T wave alteration had disappeared, and he left the hospital without it. This is not the usual sequence of events in these cases, but we are dealing here with a man who was having frequent recurrences, which I feel accounts for the failure to record the usual EKG pattern.

The malady with which we believe this patient to be afflicted has been called "acute non-specific benign pericarditis," but there is much displeasure with the term. In the first place, the disease is not always acute. Our patient, for example, has had multiple attacks during a period of three years, and at least three in the past four or five months.

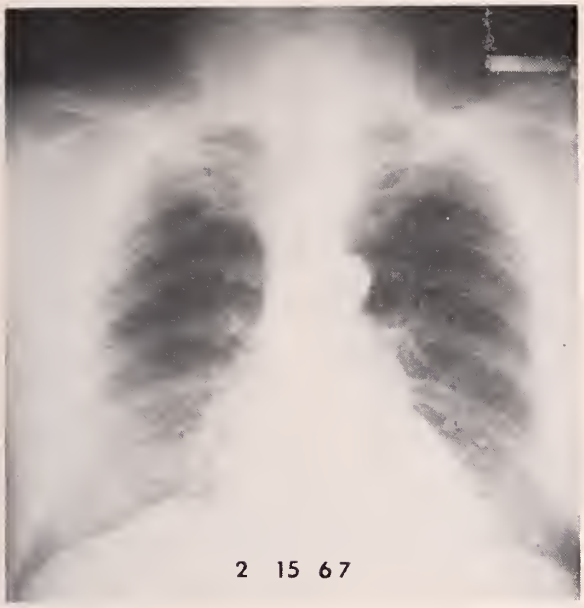

Fig. 1—Chest film on discharge February 15.

So one can hardly say that the illness is "acute." Secondly, it is not always "nonspecific," for in many instances, particularly when there have been small epidemics, there are reasons to believe that the patient has Coxsackie A or B virus infection, or influenza A or B, or chickenpox; other implicated viruses have included ECHO and those of mumps and even of infectious mononucleosis. But it is true that in sporadic cases, such as the present one, it has rarely been possible to demonstrate a specific causative agent. The possibility of a hypersensitivity reaction has sometimes had to be considered. Then, finally, the disease is not always "benign" since it may actually be very serious and complicated and a few fatalities are on record. Oftentimes it is the involvement of other serous membranes that enables us to make the diagnosis—an associated pleural effusion, or the presence of patchy, transient areas of pneumonitis. So this "pericarditis" is not always precisely pericarditis alone.

The pain of pericarditis, which is its most striking clinical feature, may be very severe and closely resemble, both in severity and distribution, the pain of myocardial infarction. Of course, because of the present patient's age, we had to consider infarction as a strong possibility. But the distinctive differential features of the pericarditis pain are that it is very commonly altered by changing position (particularly worsened by lying in the left lateral position or by twisting the trunk), and is usually relieved by sitting and

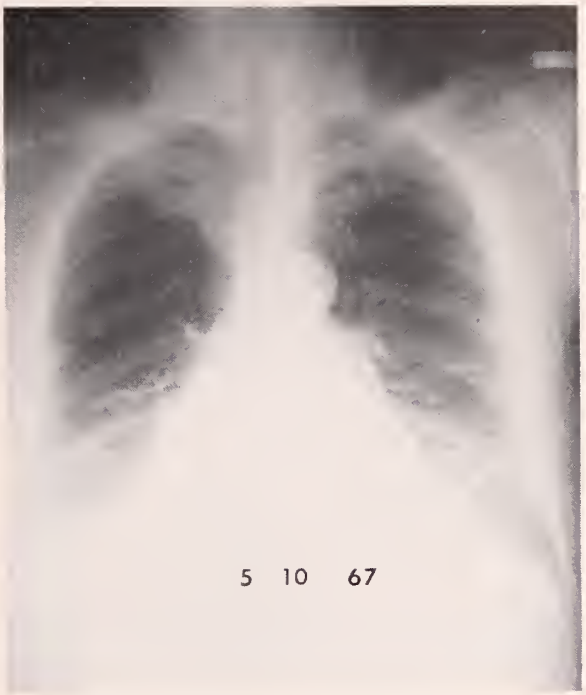

Fig. 2—Chest film on admission May 10.

leaning forward; these things are not likely to characterize the infarction pain. And the pericarditis pain is aggravated by the taking of a deep breath; infarction pain is *not*. To be sure, the myocardial infarction patient will often tell you that his pain is made worse by breathing, but you will find usually that he is too frightened to *try* to breathe deeply. In recent years it has been found that left stellate ganglion block will relieve the pain of pericarditis, which is evidence against the old belief that this pain reflects inflammation of the diaphragm or is conveyed through the phrenic nerve.

As I previously remarked, one of the useful points in establishing the diagnosis of pericarditis of the type we are considering is the history of an antecedent viral infection, which is positive in about a third of the cases. In our present patient, however, we have not been able to establish the occurrence of such an infection prior to any of his episodes. Pericardial effusion is variable in degree, but it may be helpful in establishing the diagnosis; sometimes it develops rapidly enough to produce tamponade, while in other cases it is not present at all. One need not always conclude that metastatic neoplasm is present if the effusion fluid is bloody, because there have been reports of at least sanguinous fluid in these cases of non-malignant disease.

Fig. 3—Chest film on admission May 17.

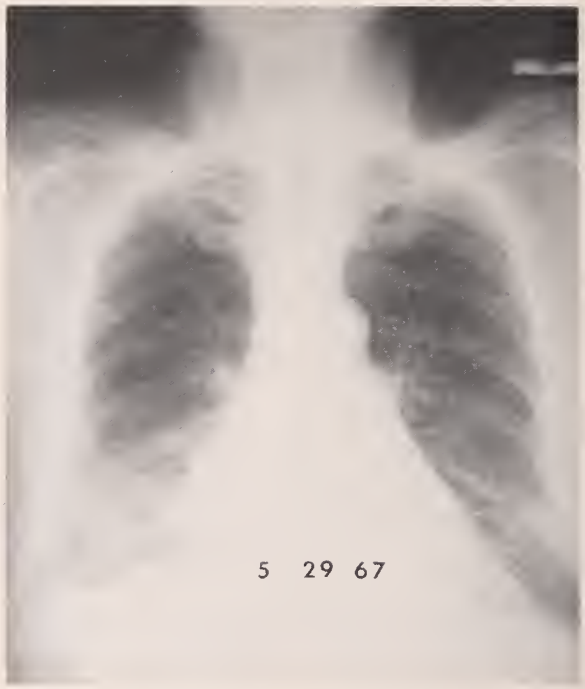

Fig. 4—Chest film on admission May 29.

About one-fourth of the patients have recurrences. In the present instance, the patient's frequent recurrences at short intervals were most helpful in establishing the diagnosis. I have had patients with four or five recurrences and have seen the report of 17 separate attacks during 16 years in one patient. I have found it advisable in my practice to warn patients of this feature of the disease.

This disorder must be differentiated from tuberculous pericarditis, which is often a quite troublesome affair, and from the pericarditis that may accompany rheumatoid arthritis or occur in the course of disseminated lupus erythematosus. It is much more frequent in men than in women, which is an important differentiating feature; in fact I cannot recall ever having seen a case in a female in my own practice.

Usually this so-called non-specific benign pericarditis can be managed satisfactorily by simple bed-rest and non-opiate analgesics. But from time to time one sees a case in which, when the pain is persistent or there are frequent recurrences, the resort to corticosteroids seems advisable. There is variable enthusiasm for this therapy in the literature, but in the latest edition of his book, Freidberg says he is quite willing to continue use of these drugs for as long as four to six months. Our present patient was placed on the corticosteroids because he had had two recurrences within a month, but the plan is to discontinue them gradually during several weeks. Of course one must consider all evidence that may point toward tuberculous pericarditis before embarking upon corticosteroid therapy.

Please be warned against the use of anticoagulants in these patients. In other words, if in a case of ostensible acute myocardial infarction, in which the anticoagulants would be employed, there is the least reason to suspect that you may be dealing instead with this type of pericarditis, do not institute anticoagulant therapy. These drugs have provoked serious hemorrhage into the pericardial space, and there have been a few fatalities.

We used to feel that this malady never led to constrictive pericarditis, but actually there have been a few instances in which constrictive, and even calcific, pericarditis has developed as early as one or two months after onset of the disease, certainly within six months. Doctor Pemberton, who will shortly discuss the surgical aspects of the malady, has seen such cases. Now this matter of surgical intervention, which essentially comprises pericardial resection, raises the question of pericardial function. Actually, patients who have had pericardial resection for one or another reasons seem to get on

quite well. Does the pericardium prevent cardiac expansion such as might occur in hypervolemia or in mitral or tricuspid insufficiency; does it protect the heart from infection that might spread from the lungs or the pleural space; does it support the heart in an optimal functional position; what purpose does the pericardium serve? We do not have precise answers to these questions.

Dr. A. H. Pemberton: The present patient is the kind who does not usually come to thoracic surgery: the patient who, though he may have multiple recurrences, develops only minimal or no effusion. The individual we see is one who has recurrent *effusive* pericarditis with the threat of tamponade. I believe that such a patient should be considered for partial pericardectomy. I do not favor merely removing a small bit of pericardium and draining the fluid, for it seems to me that, since one has gone in, it is both simple and advisable to go ahead and do a partial pericardectomy. A considerable portion of the pericardium can be removed through a small anterior incision, and the result for the patient is quite impressive. Occasionally, of course, they will drain into the pleural space, but this usually stops soon, and it is rare for these patients to have recurrences of their primary malady after the operation. Some men have favored merely doing a small window procedure to obtain tissue for diagnostic purposes, but I have not thought this advisable since one never derives more specific information than that the patient has pericarditis, which we already knew before going in.

The idea of operating for the prevention of constriction has always been enticing to the surgeon, but actually we do not know which cases would have gone on to constriction had we not operated. Tuberculosis is today one of the very rare causes of effusive pericarditis or of subsequent constriction.

Dr. Rosenbaum: Would you say, Doctor Pemberton, that pericardectomy might be done in such a patient as our present one?

Dr. Pemberton: I have never been asked to do the operation in a patient of this sort, but there have been favorable reports in the literature.

Dr. Rosenbaum: Are there particular hazards or complications associated with pericardectomy?

Dr. Pemberton: None other than those associated with any surgical procedure of this relative simplicity, provided there are not serious cardiovascular complications. Upon occasion we have had problems in dealing with a patient with severe tamponade when venous pressure was elevated and cardiac output low. Such patients, operated practically on an emergency basis, will do very badly on induction of anesthesia; we always get a needle quickly into the pericardial sac to effect immediate drainage, after which the patient picks up at once and goes on through the anesthesia and pericardectomy without further incident. In a patient such as the present one, without evidence of tamponade or any other complications, I would contemplate no troubles at all.

Dr. Rosenbaum: Doctor Pemberton, would you kindly say a few words about pericardial aspiration: what site should be used, what kind of needle, what are the hazards, who should make the tap?

Dr. Pemberton: I feel very strongly that this is not a bedside procedure any more than is tracheotomy, although of course both have sometimes been done where and when one can in emergencies. Tapping the pericardium is not without risks. In fact, for diagnostic purposes many men would nowadays prefer to put a catheter into the right atrium and observe the relationship of the right atrial wall to the cardiac silhouette; some would even inject dyes or do scans before they do a tap. I think that pericardial tap as an elective procedure should be done in the operating room where there are full facilities for resuscitation and where an electrocardiographic lead can be attached to the needle if this is felt to be desirable. One can even produce a bloody tamponade by inadvertently tapping the heart during pericardicentesis. I have had one such experience; fortunately we saved the patient but we could never have done so had we not been in the operating room.

I think that consideration should no longer be given to tapping through an interspace; the procedure is best done in the sulcus alongside the xiphoid process. It is also a mistaken idea that a large needle is necessary, for actually the longer the needle the greater the chance of getting into the right ventricular cavity.

Dr. Rosenbaum: At one time it was considered a fairly acceptable practice to introduce air into the pericardial sac to outline the space and determine how much fluid had been left behind. The procedure was also recommended for preventing constrictive peri-

carditis, but I believe it has been established that the more air we put in the more loculation we get and ultimately the more constriction.

Dr. Pemberton: We have never done this.

A Physician: What is the mortality of the pericardectomy?

Dr. Pemberton: I have lost 1 patient out of the last 14. This was an individual who was brought to the operating room with acute tamponade and practically in a moribund state. At necropsy he was proved to have had myocardial infarction. I should say that the mortality is extremely low.

Dr. Rosenbaum: As many of you know, patients who have had almost any surgical procedure on the heart may develop a so-called postcardiotomy syndrome. This was first seen in individuals who had had surgery upon the mitral valve for mitral stenosis, but before long it was recognized that the same thing occurred following operation for congenital heart disease, and we now recognize that it can follow almost any type of direct cardiac surgery. Then we realized that a small percentage of patients with myocardial infarcts have a so-called postmyocardial infarction syndrome. The manifestations in many of these patients, the character of the pain, the occurrence of pericarditis is not altogether unlike the condition we are considering here today under the title of acute non-specific benign pericarditis. But analogy can also be drawn with rheumatic pericarditis complicating rheumatic fever. I have seen at least one article in which the proposal was made to draw all of these things together into one category.

Doctor Pohlmann, would you like to tell us how large a pericardial effusion must be before one can get a positive scan? And have you other comments to make?

Dr. Guenther Pohlmann (Department of Laboratories) : Usually there has to be about 200 ml of pericardial effusion fluid. The heart scan demonstrates blood flow in the cardiac chambers, and the ratio of the transverse diameter of the scan to the transverse diameter of the cardiac silhouette on a chest x-ray film is normally 0.85 or greater.

I have questions rather than comments. Is not this patient rather old for this malady? And what findings do we need in order specifically to rule out tuberculous pericarditis? Frequently there are no characteristic pulmonary parenchymal lesions in the tuberculous cases.

Dr. Rosenbaum: In the matter of age, it is true that most patients with acute nonspecific benign pericarditis are younger than the 57 years of this patient, although I have seen a small number of patients who are in their 50s. I have never had an elderly patient with this malady.

Dr. George C. Owen: Most tuberculous pericarditis develops as the result of rupture of mediastinal nodes into the pericardium and it is true that this often occurs in individuals who do not have demonstrable pulmonary parenchymal disease. But I do not recall ever having had a tuberculous case, or seen one reported, that ran such a course as that of today's patient: who makes complete recoveries between frequent short recurrences that are promptly relieved by bed rest. A further fact militating against this case being one of tuberculous pericarditis is that somewhere along the line in the tuberculous case there is at least a fair amount of effusion, and in this man effusion has never been demonstrable in any degree. In fact the present patient's story so well fits that of postcommissurotomy, or postmyocardial infarction syndrome, that one of the astute members of Doctor Weber's department earlier raised the question whether this was a post-infarction syndrome on the basis of the x-ray appearance alone.

Dr. Rosenbaum (summarizing) : This morning we have discussed in some depth a representative case of acute non-specific benign pericarditis, not neglecting to point out the objectionable features of the designation of the malady or the differential points that require to be considered in its diagnosis. The medical treatment of such a case was developed and the surgical aspects fully considered.

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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Ambulatory Management of Chronic Obstructive Lung Disease

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■ THE TERM CHRONIC obstructive lung disease is used to designate a syndrome characterized by chronic productive cough, wheezing, and dyspnea. Three narrower entities, chronic bronchitis, emphysema and asthma, can frequently be identified within the syndrome. Since more than one of these entities may exist in a given patient, and since accuracy in diagnosis may be difficult, the term chronic obstructive lung disease provides a useful label in our present state of knowledge.

Asthma is defined as an unusual sensitivity of the bronchial tree manifested by the development of airway obstruction which is reversible in nature, either spontaneously or in response to therapy. Chronic bronchitis is also defined in clinical terms as chronic productive cough which is present for two or more years without a discernible etiology. Emphysema is defined in anatomical terms as an enlargement of the respiratory air spaces with destruction of their septa and coalescence of adjacent air spaces. Chronic bronchitis and emphysema may exist alone, with or without obstruction. However, they usually occur together, accompanied by obstruction. The causal relationship between these entities remains uncertain. Asthma, even when long-standing, does not appear to lead to the development of emphysema. The relationship between airway obstruction, asthma, chronic bronchitis, and emphysema is depicted graphically in Figure 1.

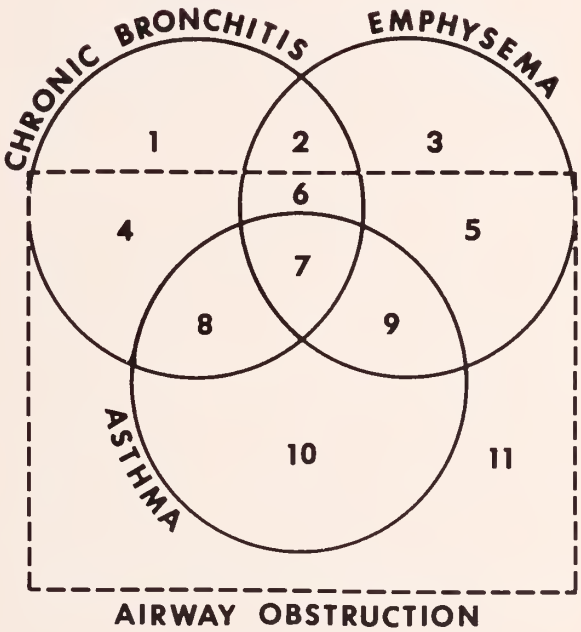

Fig. 1—Venn diagram depicting the relationship between chronic bronchitis, emphysema, asthma, and airway obstruction. Chronic bronchitis and emphysema may occur alone without airway obstruction, subsets 1 and 2; chronic bronchitis and emphysema may occur together without airway obstruction, subset 3; chronic bronchitis and emphysema may occur in pure form with airway obstruction, subsets 4 and 5; or they may be combined, subset 6; in addition they may be associated with asthma, subset 7. Asthma may occur with chronic bronchitis, subset 8, with emphysema, subset 9, or in pure form, subset 10. Asthma, of course, always occurs with obstruction. Finally airway obstruction may occur without any of these three conditions, as in upper airway obstruction, subset 11. The areas of the subsets in this diagram bear no relationship to the actual proportion of cases filling the subsets.

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Supported in part by Research Grant HE-09630 from the US Public Health Service.

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The therapy of chronic obstructive lung disease may be divided into three categories: (1) specific therapy which attempts to alleviate the cause of the obstruction, (2) symptomatic therapy which relieves the symptoms of airway obstruction, and (3) secondary therapy which is directed against the deleterious effects of long-standing airway obstruction.

1. Specific Therapy

Specific therapy in bronchial asthma consists of avoiding known environmental substances which precipitate an attack, such as pollens or animal dusts. Hyposensitization injection therapy is useful when it is indicated by a careful history and skin tests. Little is known of the etiology of chronic bronchitis or emphysema, but epidemiological studies have shown a much higher prevalence of these forms of chronic obstructive airway disease in cigarette smokers than in nonsmokers. Therefore, these individuals should be urged to stop smoking. Exposure to irritating inhalants in the working environment should be investigated and changed whenever feasible.

2. Symptomatic Therapy

Airway obstruction in chronic obstructive lung disease may be divided into reversible and nonreversible components, and symptomatic therapy is directed at the former. A nonreversible form of obstruction develops in emphysema as a result of expiratory collapse of the smaller airways due to loss of their supporting, connective tissue fibers. Reversible obstruction is due to mucosal edema and congestion, smooth muscle spasm, thick secretion, and infiltration of the wall of the bronchus by inflammatory cells. The exact combination of causative factors will vary from patient to patient and in the same patient at different times.

Bronchodilators and Decongestants

Oral bronchodilators, such as ephedrine and other sympathomimetic drugs, given usually in a mixture with a barbiturate and a small amount of theophylline, are baseline therapy. These preparations are often all that is necessary in the milder cases.

The *inhalation* of bronchodilator or vasoconstrictor drugs is a mainstay of therapy. Isoproterenol is representative of the bronchodilator agents and phenylephrine of the vasoconstrictor agents; racemic epinephrine has both bronchodilator and vasoconstrictor properties. These drugs may be given in a concentrated or diluted solution. A highly concentrated solution mixed with freon as a propellant is marketed in a portable pressure nebulizer readily carried in pocket or purse. It can be used either to relieve or to prevent airway obstruction. Rechargeable glass or plastic nebulizers, which are manually activated by a rubber bulb, can also be used to give bronchodilator aerosols.

When thick secretion is a problem, the bronchodilator drugs are best given in a more dilute aqueous aerosol; for example, 5 drops of ½% isoproterenol and 5 drops of ¼% phenylephrine mixed with 2 ml of normal saline and administered with a hand-held nebulizer activated by an electric or manual air compressor. Aerosol therapy can also be very effectively administered with one of the many devices for intermittent positive pressure breathing therapy. Frequency of treatment may vary depending upon the exacerbation of symptoms.

Aminophylline is one of the most valuable bronchodilators. Since aminophylline at adequate oral doses has the tendency to produce nausea and vomiting, rectal suppositories can occasionally be used although they may also become irritating. In the most difficult cases, retention enemas containing 0.25 to 0.5 gm of the drug, given as often as every eight hours, are highly effective. Most patients tolerate this form of treatment without difficulty for long periods of time. The larger doses should be avoided in persons over age 65 because of the greater prevalence of gastrointestinal and cardiovascular side effects.

Sputum Thinning and Mobilization

Since thin sputum is more readily mobilized, patients should drink three liters of water per day to avoid any increase in sputum viscosity due to dehydration. Iodides (0.5 to 1.0 gm t.i.d.) and glycerol guaiacolate (100 mg q 4–6 h) are probably the most effective oral expectorants. Aqueous aerosols, as described above, are more effective than oral expectorants and are reserved for difficult cases because they are more time consuming and expensive to administer. Aqueous aerosols not only thin secretions by decreasing their viscosity but also lubricate the surface of thick mucus in the bronchial tree so that it may be more easily mobilized and expectorated. Inhalation of steam from

hot water in the bathroom lavatory, using a towel as a simple tent, is often effective in thinning secretions and may be better tolerated than cold aerosols in the presence of acute infection. In problem cases or during an exacerbation of symptoms, 2 ml of 10% acetylcysteine given every 3 to 4 hours is helpful in thinning sputum. Because of its tendency to produce bronchoconstriction, acetylcysteine should be used cautiously in asthmatics and should be mixed with a bronchodilator such as isoproterenol. Postural drainage and chest wall clapping administered by a member of the family are helpful in selected cases.

Antibiotics

An exacerbation of symptoms in a patient with chronic obstructive lung disease is frequently accompanied by a change in the character of the sputum from mucoid to purulent, indicating the presence of infection. Fever and elevated white blood cell count are generally not present. The administration of an antibiotic such as penicillin, ampicillin, or tetracycline for 7 to 14 days is then indicated. In most instances sputum cultures show only oral flora, such as alpha hemolytic streptococci and neisseriae; pathogens are found in less than half of the cases and are almost invariably one or both of the pneumococci or hemophilus influenzae. Therefore, cultures need not be carried out before beginning antibiotic therapy. During or after a course of antibiotics, cultures and sensitivities are helpful if the patient continues to be symptomatic with purulent sputum. Prophylactic antibiotic therapy given in either continuous or intermittent regimens will decrease the duration and severity of exacerbations of obstructive lung disease. However, it is my practice to instruct the patient in recognizing purulent sputum and to provide him with a 7-day course of antibiotics. He is advised to begin such treatment, after consultation, when a definite change in sputum character occurs. In most patients who are able to follow such a regimen, the results appear to be as effective as the more expensive prophylactic antibiotic treatment.

Corticosteroids

In general, corticosteroids are not helpful in patients whose chronic obstructive lung disease has no asthmatic component. Where there is doubt of the diagnosis, a short trial course of steroids may be given. Objective evidence of improvement should be sought before undertaking long-term steroid therapy. This evidence may be the diminution of requirement of other symptomatic therapy, or the improvement in exercise tolerance, spirometric values and/or blood gases. Corticosteroids are of great benefit in asthma when other forms of vigorous symptomatic therapy have failed to control the disease. The minimum dose of oral steroids necessary to relieve symptoms should be determined for the individual patient; as little as 2.5 mg of prednisone or its equivalent, administered three times daily may be sufficient. It is often possible to avoid hospitalization by transiently increasing steroid dosage.

3. Treatment of Secondary Effects of Obstruction

A number of measures may be used to counteract some of the secondary effects of persistent obstruction in patients with severe disease. Breathing exercises designed to improve emptying of the lungs are helpful. Patients are taught to strengthen the abdominal muscles and to emphasize prolonged slow expiration. In selected cases the administration of oxygen by nasal cannula at a flow of 1 or 2 L/min corrects hypoxemia and provides effective organ assistance. Oxygen is generally given for short periods of time so that the patient may carry out tasks such as shaving and defecation without suffering intolerable dyspnea. In the severe case where such therapy is prescribed, the patient must be warned against the use of oxygen during sleep, especially during an exacerbation, because of the great risk of producing alveolar hypoventilation and carbon dioxide narcosis. When skeletal muscle deconditioning has resulted from prolonged inactivity, graded exercises, given with oxygen may decrease ventilatory requirements, and improve exercise tolerance. Lung function is not affected by such a program.

The therapeutic regimen is not appreciably different when right heart failure has occurred; the emphasis should still be on pulmonary therapy. Diuretic therapy may be required and correction of hypoxemia is important. Digitalis should be used cautiously in these patients, since digitalis toxicity is commonly associated with hypoxemia. Tachycardia is often persistent and may be misleading when used as a guide to digitalis therapy.

In conclusion, the exact regimen used in any patient will depend upon the severity of his disease and his response to the various measures. In severely ill patients, who have been hospitalized, it is advisable to duplicate the ambulatory therapeutic regimen preceding discharge. By following the above described approach, it is anticipated that many patients can be kept functional either at work or in a self-help situation, and the need for repeated hospital admissions is minimized.

Summary

The term chronic obstructive lung disease comprises three conditions: chronic bronchitis, asthma, and emphysema. The principles of treatment are the same in all of these conditions: the prevention and relief of reversible airway obstruction and the treatment of the secondary effects of chronic airway obstruction. Reversible obstruction is due to bronchial smooth muscle spasm, mucosal congestion and edema, inflammation, and thick secretion. Irritation should be reduced by cessation of smoking, and where feasible, the removal of environmental factors, such as pollen or dust. A bronchodilator and sputum thinning regimen should be established. Infection should be controlled by appropriate administration of antibiotics. In patients with advanced disease, breathing exercises and graded skeletal muscle exercises with or without oxygen are often helpful.

WISCONSIN'S HEALTH by E. H. JORRIS, M.D., State Health Officer

MEASLES ERADICATION CAMPAIGNS HELP REDUCE INCIDENCE TO NEW LOW

Freedom from measles can be achieved in Wisconsin. When final figures for 1967 measles cases were tabulated, the results showed that widespread county campaigns plus activity by physicians of the state reduced the incidence of measles to a low total of 1,985 reported cases last year. During the previous 10-year period the record high count was 72,993 cases reported in 1958, the low was 16,044 cases in 1962, and the average was 36,516 reported cases.

Measles eradication campaigns have been conducted in 49 counties and three more counties have programs scheduled. Three counties—Milwaukee, Dane, and Langlade—have had partial programs, and 17 counties have had no measles prophylaxis programs.

Counties without public measles immunization programs are: Douglas, Rusk, Taylor, Marathon, Eau Claire, Buffalo, Trempealeau, Jackson, Calumet, Fond du Lac, Dodge, Washington, Ozaukee, Walworth, Iowa, Lafayette, and Grant.

Measles vaccine furnished by the Division of Health was administered last year by physicians to 35,467 children in their offices and to 81,884 children at community sponsored programs.

From 1957 to 1967 there were 83 deaths resulting from measles reported in Wisconsin. This needless disease of childhood can be eradicated in Wisconsin by attacking the disease on two fronts. First, parents must be encouraged to have their children vaccinated for measles by their family physician when they reach 12 months of age. Second, communities should conduct "end measles" immunization campaigns directed primarily at susceptible children one through 12 years of age.

Continued campaigns are essential for "catching up" on the backlog of children who need protection. The Division of Health will supply measles vaccine and personnel to assist in public campaigns in counties or cities.

HOSPITAL DISCHARGE SURVEY

A study of hospital use and of demand for hospital facilities in Wisconsin is being conducted by the Division of Health of the Department of Health and Social Services.

Participating in the study are 161 short-term hospitals, representing 21,831 beds, and 55,000 patient discharges per month.

When the study is completed, much more will be known about hospitalized patients, where they are from, how old they are, how bills are paid, and as to where they are discharged.

Information secured from discharge records for the months of October, 1967 and March, 1968, will form the basis of the survey. These data will be helpful in planning health care services. The study may also provide a basis for appraisal of the impact of Medicare and Medicaid on the general hospitals of the state.

The study will provide important information about the age, sex, and residence of patients, the medical diagnoses, number of days of hospital care, and place to which they are discharged. The data will be tabulated for planning purposes. When the study is completed, more will be known about the conditions and where the patients are being hospitalized than has been known in the past. This study will provide a picture of hospital care received and the demand for hospital facilities by area in Wisconsin.

THE PRESIDENT'S PAGE

HAROLD J. KIEF, M.D.

SMS means aggressive leadership

Quo Vadis—The Professions

"Eternal Vigilance is the Price of Liberty"

■ WHEN A MAN TRAINED in a profession begins to practice, he places himself in a singularly vulnerable position. He lays his ideals on the line. He has completed years of study, struggled to command an enormous body of knowledge and he's developed a basis for sophistication in (his) professional judgments. When he has achieved this status, he sees himself as something more than a member of his profession. He is an individual, able to offer needed services to those in need of his services—and on an extremely personal basis.

Every worthy professional considers it a privilege to be able to serve the individual who seeks his help and to protect that individual's interests as if they were his own. While we consider it a privilege and realize that each privilege has a counter balancing responsibility, there are those who consider only our obligations. They would have us believe that we are to deal not with individuals, but with a vast anonymity called "the public" which has somehow obtained a collective mortgage on the capacities which we have labored long and hard to achieve. It is here that our own ideals come under attack.

I'm not speaking only of physicians, mind you, but of all true professionals. As professionals, we deal in health, education, liberty and justice, economic resources, technological extensions of physical capabilities—things and services which are basic and essential to the character of life and to life itself. In a sense, each of these things extend in some way the ability of the individual to achieve independence or to remain independent. We work every day with people whose problems are as varied as their personalities. In the everyday exercise of professional judgments we distinguish and differentiate, interpret the facts and implement our services in each individual case. In order to maintain the true character of professionalism, we must be able to treat each person as an individual—to assume for the moment all his hopes, aspirations and ideals—to assume his vulnerability in a particular instance.

The initial responsibility for maintaining an atmosphere of freedom in which to practice rests squarely on the shoulders of the professionals themselves. If they shrug, it tumbles into the laps of various proliferating bureaus, commissions, agencies, boards, plans and foundations—all of which claim to represent the interests of that vast anonymity "the public"—most of which are sorely lacking in representation from the professions upon whose abilities they feel so free to draw.

If we don't maintain the charge of setting our goals; planning the equitable distribution of our services and the standards of our practices, someone else is always available and ready to do it for us. This can only result in disintegration of the professions through the sacrifice of individual professional integrity, freedom, ambition and achievement. For physicians, the State Medical Society, the county societies, the Academy of General Practice and the specialty societies are organizations which with our active support are extensions of our personal efforts.

The Wisconsin Association of Professions (WAP) provides a means for thinking and articulate members of each profession to join with the leaders of other recognized professions to approach problems which are shared by professions to reach both the public and the indifferent members of the professions.

continued on next page

The expressed purposes of WAP are: to promote free interchange of opinion toward better understanding among members of the various professions; to promote programs and measures for the protection of the public and the professions against encroachments by those who are not qualified; to foster higher standards of professional ethics and conduct; to promote programs designed to offer professional and pre-professional students more adequate preparation for professional life; to assist individual professionals in meeting problems of their respective professions; to stimulate and foster leadership by the professions in public service activities on community, state, and national levels.

Through the Wisconsin Association of Professions, we can effectively join with others—not to preesrve the professions per se, but to preserve a climate that is conducive to the freedom of every professional to serve the public and in a manner which is to the advantage of all.

To my medical colleagues who have not joined WAP, I urge you to do so. An application form will be readily forthcoming in response to your request addressed to the Association in care of your State Medical Society. The following quote from John Philpot Curran is as applicable today as it was in 1790 when he said:

> "It is the common fate of the indolent to see their rights become a prey to the active. The condition upon which God hath given liberty to man is eternal vigilance; which condition if he break, servitude is at once the consequence of his crime and the punishment of his guilt."

W D Kief MD

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison, Wisconsin 53701.

Interprofessional Code
An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

Guide to The Service Corporation Law
A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

Code of Necropsy Procedure
A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

Hearing Conservation Programs for Wisconsin Industries
Some recommended standards and principles for providing a hearing conservation program in industry.

Occupational Health, A Guide for Medical and Nursing Personnel
General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.
New expanded edition—$5.00 with binding, $4.00 without binding. Ideal for any industrial plant with nurse service.

Find Your Future in the Health Field
A career guide (the health careers brochure).

Guide to Immunization Planning
An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

Inspection of Medical Records
An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

Principles for Transporting the Ill and Injured
A guide for providing emergency transportation services, including model community and state ordinances.

School Vision Screening Program
An outline to facilitate the development of a program to detect significant visual defects among school children.

First Aid Chart

Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959
Relating to fee splitting between physicians and others.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

APRIL 1968
Vol. 67 No. 4

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

IN MEMORIAM

John H. Houghton, M.D.

■ ALMOST TO THE END of his time, Dr. John Houghton remained true to his life's style. Even though racked with pain and aware of the terminal nature of his illness, he attended meetings of the State Medical Society Commission on Medical Care Plans because he placed the work of the doctor in his social and economic context far beyond his own comfort and convenience. In retrospect, it is hard to imagine the price paid by this frail-appearing but iron-willed physician for his consistent devotion to his ideal.

John Houghton's premature death last March 25 is a loss not only to his family and friends and to the community of Wisconsin Dells, which he served so long and with such dedication, but also to the entire medical profession to which he gave so unstintingly of his time and energies. As an active participant in the activities of organized medicine, in addition to those of local civic and church organizations, he typified the "complete physician" whose horizons encompassed the social as well as the physical welfare of his fellow men.

Although Doctor Houghton practiced in only one community since he received his license in 1932, the scope of his interest extended to the borders of the State of Wisconsin and well beyond. From 1950 through 1954 he served as delegate of the Columbia–Marquette–Adams County Medical Society and was elected president of that organization for the years 1950 to 1952. He received several appointments in the State Medical Society of Wisconsin and represented the third district on the Council from 1956 to 1963 before his election to the presidency, an office he performed with great distinction for the year 1965–1966.

In 1949–1950 he served on a special President's Committee on Medical Care Survey, established by the House of Delegates to determine the effectiveness of medical care programs to meet the needs of Wisconsin citizens, with special emphasis on those engaged in industrial activity. He was also a member of the management survey study committee in 1963–1964. Since 1961 Doctor Houghton was a member of the Commission on Medical Care Plans which directs the operation of Wisconsin Physicians Service.

In 1966 Governor Knowles appointed him to the State Board of Health. In addition to all this professional activity, Doctor Houghton found time to participate in the activities

of the Elks, Chamber of Commerce, Board of Education, Kiwanis Club, and local industrial groups in Wisconsin Dells.

Though he knew that his days were numbered since last June, Doctor Houghton continued his customary involvement in the life of his community selflessly and cheerfully—fending off the spector of death that faced him with service to his community.

A few weeks before he died, Doctor Houghton made a sizeable contribution to the State Medical Society Charitable, Educational and Scientific Foundation to establish an award to honor outstanding medical students. In accordance with his instructions the award will be granted to one or more students, nominated by the deans of Wisconsin's medical schools and selected by the CES Foundation, who "through scholastic excellence, extracurricular achievement and interest in the activities of medical organizations" give indication of their becoming men like himself, who work through their county, state and national medical organizations to achieve the great goals of public health.

The encouragement of young people in the medical profession and the responsibility of the leadership of the state society to the medical student were projects close to his heart. Those who wish to pay tribute to the memory of this fine doctor and great human being can do no better than to donate to the fund that he himself established, so that the expression of his life's ideal may be expanded.

May his memory be as a blessing to those who come after him.—D.N.G.

Familial Disease, Rapport, and Consent

THE CLINICAL and biochemical manifestations of the familial syndrome of polyendocrine adenomatosis could not be completely studied in a patient presented elsewhere in this issue of the Journal. Post-mortem examination was refused. This made it impossible to evaluate all glands histologically and assay tissues for peptide hormone production.

In spite of numerous attempts by the physicians involved with the patient and his family (including surgeons, endocrinologists, gastroenterologists and psychiatrists), at no time could the significance of genetic and biochemical areas be communicated in such a way that full cooperation was possible. On one occasion, the patient's father and sister did allow evaluation of a serum calcium, which was normal. No other studies were achieved.

Care for gastrointestinal symptoms was precipitated usually by bleeding episodes. Psychiatric help for a severe depressive reaction was accepted after much urging, and relief occurred only with institution of electroshock therapy. No genuine motivation for the patient to return to his former occupation could be generated.

The "real story" of this case report lies in the inter-personal relationship in the family complex, which just "could not be cracked," in spite of all modern medicine, surgery, psychiatry, and sophisticated biochemistry had "to offer."

In writing about pathological physiology and the ultimate synthesis and application of its principles to scientific medicine, a quotation by Virchow[1] seems pertinent:

> "It is not an esoteric science that runs beside medical practice like a little doggy that gives joy and pleasure to his master in the latter's idle hours. In looking for the eternal laws of organic life it belongs to the innermost nucleus and essence of medical knowledge."

—FRANCIS N. LOHRENZ, M.D., Marshfield

[1] AckerKnecht, Erwin R.: *Rudolf Virchow, Doctor, Statesman, Anthropologist*, University of Wisconsin Press, 1953, p. 54.

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LETTERS

"PERIPATETIC PRACTITIONER"

To DOCTOR GOLDSTEIN:

As you pointed out in your introductory paragraph, Dr. A. Y. Gerol's "forceful" editorial in The Wisconsin State Medical Journal (67:106, 1968) was stimulating and thought provoking. Dr. Gerol's viewpoint is characterized by lack of knowledge of the facts as they apply to the relationship between members of the Medical School and the practicing community. One may surmise that Dr. Gerol's pique is based on an unfortunate incident(s) that may have affected him directly in dealing with specific member(s) of the faculty. After 15 years of cordial relationship with my practicing colleagues, and as a full-time member of the faculty, I can assure Dr. Gerol that most full-time members are not interested in practice, per se, and even if they were, the demands made on their time by teaching and research activities limit the time they can effectively spend in "practice."

Private patients are accepted, in the Department of Medicine at least, only if they are referred by a private physician, only if they represent a disease or discipline within the consultant's range of interest, and then only on the terms that the patient's physician assume continuing responsibility for the care of the patient. This limitation of practice time, has led to the more frequently heard accusation that faculty members are shut in an ivory tower and are unwilling to make their talents available to the public. Over and above this, since an important function of the teacher is to teach himself out of "business," may I remind Dr. Gerol of the young graduates of our school and hospital training program that replace their teachers in the front line of practice! The net effect of this may be to promote the stature of some faculty members to that of a "consultant's consultant"—but certainly there is not interference with the practice of medicine intended here.

Whether Dr. Gerol is right or wrong is not the important issue. In a democratic society, everyone is entitled to air his opinion in various ways. He can pass out handbills, write letters to the editor, picket, hire a hall, advertise, climb on a soapbox, etc., etc. Dr. Gerol chose to write an editorial, which was published with semi official blessing in the State Medical Journal. Since many full-time faculty members are dues-paying members of the State Medical Society, one must conclude that they are being misrepresented, as well as those practicing physicians who do not adhere to Dr. Gerol's beliefs. A private viewpoint such as this, should have been published as a letter to the editor.

ANTHONY V. PISCIOTTA, M.D.
Professor of Medicine
Marquette School of Medicine

To DOCTOR PISCIOTTA:

I agree with your comments about Dr. Gerol's views but it seems to me that they do represent a minority opinion, or at least represent the confusion that exists in the private practice sector. My principal reason for using his contribution was to try to stimulate interest in the forthcoming "Town-Gown" symposium on March 23. As you may have heard, the first symposium held last year was poorly attended.

Dr. Gerol's editorial did not have "semi official" blessing or any other sort of approval. As stated in the publication information in each issue, ". . . the views expressed, if initialed or signed, are those of the writer . . .". No reader should conclude that any editorial in the WISCONSIN MEDICAL JOURNAL represents an official position of the State Medical Society.

Thank you for your letter, Dr. Pisciotta, and I hope that material in future issues will correct any faulty impressions created by this guest editorial.

D. N. GOLDSTEIN, M.D.
Kenosha

A VOLUNTEER FOR HONDURAS

To the EDITOR:

Thank you for your kind letter and inquiry regarding my volunteer work in Honduras.

My wife and I are participating in a program for the United Church Board for World Ministries, in which we will be serving for a period of ten weeks in San Pedro Sula, Honduras. The volunteers pay their own way to and from the nation in which they work and receive only lodging from the missionary board.

I am working in the government hospital, which is primarily a charity hospital. We have an eye clinic every morning and afternoons are devoted to surgery. My wife is a graduate nurse and assists me in surgery.

As in most underdeveloped nations Honduras has a severe shortage of both medical personnel and hospital facilities. The great majority of the people are unable to pay for medical attention, and the need for help is very great. The cooperation of the local medical authorities and physicians has been outstanding.

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

We are extremely busy, but very happy, because we are doing work which would otherwise probably not be done. By necessity, only the most severe cases are selected for surgery. We are finding our trip here most gratifying.

OLIVER M. HITCH, M.D.

EDITOR'S NOTE: Doctor Hitch, a Green Bay ophthalmologist, and his wife left for Honduras in January for a three-month stay. It was felt that a report of his work might be of interest to other physicians. Doctor Hitch is a native of Princeton, Ind., and is a 1947 graduate of the University of Indiana School of Medicine.

CAN YOU HELP IN COMA STUDY?

To the EDITOR:

The ability of physicians to maintain life for very long periods in the unconscious patient raises the question as to how long such skills should be deployed. As physicians we are eager to promote the recovery of everyone who can do so. In order to deprive no one of his chances on this score it is relevant to know the longest periods of coma which have been followed by useful survival.

A committee of the Massachusetts General Hospital is studying our own records and the world literature to determine pertinent features in all patients who, *despite coma for over 5 weeks*, have made a useful recovery. We think it is vital not to overlook any well documented patient in this category. We should be grateful if any reader of this journal would draw our attention to any case published under a title which is not indicative of survival after prolonged coma. We are also eager to receive accounts of such cases as yet unreported. A publication incorporating our own and others' data is planned.

WILLIAM H. SWEET, M.D., D.Sc.
Chief, Neurosurgical Service
Chairman, Committee on Management of the Unconscious Patient
Massachusetts General Hospital
Boston, Mass. 02114 USA

STATUS OF TESTIMONIAL ADVERTISEMENTS

Having been deluged in recent months with irate complaints from physicians charging that those physicians who lend the use of their names for testimonial advertisements, many of which contain prominent photographs of the physician, are "prostituting the profession," the AMA's Judicial Council has reiterated its opinion providing a guideline for physicians in their relations to commercial enterprises.

In rendering its opinion the Judicial Council considered only the advertisements in question. It did not assess the conduct of the physicians involved because (1) no charges had been brought against any physician as an individual and (2) the Council refused to impute improper motives to any of the physicians who, it felt, acted without any intent to violate ethical standards.

The Council concluded, however, that it was imperative to warn physicians of the consequences of providing testimonials without fully considering their potential impact upon the profession.

The complaints have stemmed from a rash of recent newspaper, Sunday supplement and magazine advertisements and also sensationalized "book jacket" copy prepared by publishers of books written by physicians.

Here is the opinion rendered by the Judicial Council:

"It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises."

A few copies of "Supply, Demand and Human Life," a six-page, color pamphlet describing the increasing importance of blood banks and the significant role fulfilled by voluntary blood donors would be a worthwhile addition to your supply of reception room literature.

Complimentary copies are available from the AMA's Department of Environmental Health, 535 North Dearborn, Chicago, Illinois 60610. The pamphlet points out that the annual blood requirements of the nation currently are being provided by only three per cent of the eligible donor population.

REPRINTS: EXAMINING THE MOUTH

Reprints of an article which describes a simple but effective procedure for examining the mouth are now available to interested physicians and dentists. Called "Examination of the Mouth," the pamphlet is illustrated with 24 figures, 14 of them in color, and contains 9 case reports. Authors are Drs. William L. Ross, Robert H. Johnson, and Richard L. Hayes, who stress the value of such examinations in detecting a variety of diseases, including malignancies.

Single copies of the article, which originally appeared in the August 1967 issue of *GP*, are free upon request. Requests for copies in excess of 10 should be accompanied by an explanation of how the copies will be distributed or used. Write Information Services, Cancer Control Program, Public Health Service, 4040 North Fairfax Drive, Arlington, Virginia 22203.

SECTION

OPHTHALMOLOGY

APRIL 1968 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

ANNUAL MEETING OPHTHALMOLOGY PROGRAM

Complete details of the Ophthalmology program on May 16 and 17 during the annual meeting of the State Medical Society in Milwaukee will be found on pages 44 and 45 of this issue.

LOW VISION CLINIC IN MILWAUKEE HELPS 700 PERSONS IN FOUR YEARS

This optical aids clinic was established in December, 1963 and has been serving persons with subnormal vision since February of the following year. Approximately 700 severely visually handicapped individuals have received specialized low vision evaluations during this four-year period.

This statewide program was originally started as a three-year demonstration project through the Vocational Rehabilitation Administration, the Marquette University School of Medicine, the Rotary Club of Milwaukee, the Milwaukee Ophthalmic Institute, the State Division of Vocational Rehabilitation, the State Services for the Blind, and the Curative Workshop of Milwaukee. Upon termination of the project, the Rotary Low Vision Clinic became a division of the Curative Workshop of Milwaukee, a comprehensive rehabilitation center, and United Fund Agency, a certified agency under Medicare and Medicaid. The State Vocational Rehabilitation agencies also recognize the value of the Clinic to their clients and authorize evaluations for them. Fees for persons from the Greater Milwaukee Area can be adjusted or cancelled in accordance with their financial ability to pay.

Patients ranging in age from 5 to 95 years have been referred to the Clinic by 133 different opthalmologists from throughout the State. Special referral forms have been developed to facilitate patient referral.* Complete reports of findings and recommendations are sent to the referral source upon termination of services.

Dr. John Sella, current Clinic Ophthalmologist, and Mrs. Madalyn Braun, Program Coordinator, combine their efforts and attempt to coordinate their services with those of other existing programs in a comprehensive approach to rehabilitating the partially sighted. In addition, they are available as a teaching staff to train residents in ophthalmology and inform professional personnel of private, public, and interested voluntary organizations concerning the potentials and problems of the person with subnormal vision.

An analysis of data, collected during the three-year project period, and opinions of referring ophthalmologists have indicated that the program provides a much needed service. The patient load has grown since 1963, and it is expected to continue to grow as more ophthalmologists become aware of the facility and utilize this consultative service.

* These forms may be obtained by writing the Low Vision Clinic, 750 No. 18th St., Milwaukee, Wis. 53233; tel.: 342–2181.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

The Milwaukee Ophthalmological Society has upheld its reputation as having interesting speakers of national prominence on its 1967–68 program.

On Nov. 28, 1967, Dr. A. E. Braley, professor of Ophthalmology at the University of Iowa, presented the second Haesseler Memorial Lecture. Dr. David Shoch, professor of Ophthalmology at Northwestern University Medical School, presented the second lecture in the series on Jan. 30. Dr. Miles Galin, professor of Ophthalmology at New York Medical College, appeared Feb. 27.

A program on Mar. 26 featured a panel on "Reading Disabilities." Dr. Otto Wiegmann of the Marquette University Medical School Eye Department presented the subject, "Diagnostic Occlusion in Squint," at the Apr. 23 meeting.

On Thursday, May 16, the date of the annual meeting of the State Medical Society's Section on Ophthalmology, Dr. J. Lawton Smith will present a paper on "Neuroophthalmological Motility Problems."

The Milwaukee Ophthalmological Society meetings, held at the University Club of Milwaukee, have been well attended. These meetings, held six times a year, are of interest to other ophthalmologists around the state. The meeting starts with a preprandial session at 5:30, followed by dinner, scientific and business meetings. Guests are welcome, and programs are available upon request to the secretary: James V. Bolger, MD, 1212 W. Wisconsin Ave., Milwaukee, Wis. 53233.

WISCONSIN–UPPER MICHIGAN SOCIETY OF O–O

The spring meeting date of the Wisconsin Upper–Michigan Society of Ophthalmology and Otolaryngology has been changed to May 11–12 at the Manitowoc Motor Hotel, Manitowoc. Speakers will be Drs. Peter A. Duehr, Rodney J. Sturm, and Charles R. Taborsky of Madison.

THE MEDICAL STUDENT FORUM

Devoted to the expressions of the medical students at the University of Wisconsin and Marquette medical schools through association with the Student American Medical Association. A feature originated by the State Medical Society of Wisconsin to stimulate closer relationships with the physicians of tomorrow. This space is offered monthly to both schools on an alternating basis, with copy deadline the first of the month preceding the month of publication. Statements and opinions contained herein are those of the students.

MARCH 1968

EDITOR'S NOTE: The following paragraph was inadvertently omitted from the March page:

I hope that this has explained the reasons for the formation of the Madison Student Health Organization. If you agree with our purpose and activities we welcome your philosophical and financial support: Madison Student Health Organization, % University of Wisconsin Medical School, Madison, Wisconsin.—PAUL A. WERTSCH, Med. II, University of Wisconsin, Madison.

APRIL 1968

ONE OF THE MOST successful activities of SAMA at Marquette has been the annual Medical Career Day. Since it began in 1953 this program has become a model for similar "days" at other medical schools across the country.

The primary purpose of Career Day is to give high school and college students an opportunity to see what goes on in a medical school and to motivate them towards a career in the Medical Sciences. Although the format of the program has changed somewhat over the years, it basically is still a series of demonstrations and displays which try to show how and what medical students learn. In order to do this in the past, each department of the medical school was asked to display graphically, by way of an experiment or other presentation, the kind of subject it teaches. Usually this was handled by the faculty of the department and its graduate students. However, last year it was decided that due to the predominance of younger students as visitors and the general unrelatedness of the different exhibits, a more simplified and unified approach would be attempted.

MARQUETTE MEDICAL CAREER DAY

Last year's Career Day was then placed in the hands of the medical students themselves and built around the central theme of the lung. Included in the program were Pathology department specimens of diseased lungs, radiographs of normal and diseased states in a Radiology presentation, a combined Microbiology-Preventive Medicine look at tuberculosis, and a more involved display with the Physiology department. This presentation included the measurement of various lung parameters in "normal" medical students and "pathological" patients. The hit of this exhibit were two men with emphysema who proceeded to "breathe-out" matches held at arm's length and blow-up balloons one after another, much to the dismay of the student's who ran the demonstration.

Although the Anatomy department was unable to follow the theme of the lung, it once again held its title as the student visitor's "favorite of the day" with an exposition of the muscles of the forearm on a cadaver. They were also able to set a new record of losing only three visitors to the rigors of the Anatomy lab, fortunately none after lunch. In addition to the Medical department displays the other paramedical groups also had presentations. These included the departments of Medical Technology, Physical Therapy, and Nursing.

ANATOMY AGAIN FAVORITE

This year the Medical Career Day will be held on Saturday, April 27, at the medical school. This is an all day affair which begins with a talk by one of the physicians connected with the school. It is hoped this year that we can use as our central theme either the heart or the brain and CNS. However, no matter what topics will be covered we hope to have at least as much response as we have had in previous years. Although we are aiming primarily to the college student in the Medicine aspect of the day, the other representatives will be aiming at the high school level, and in the past it has been primarily a high school majority group of visitors. One of the underlying hopes is that we can elicit some response to the idea of medical and paramedical careers; and just being able to talk to young students is a good opportunity for them and for us.

PERSONAL CONTACT IMPORTANT

While the Medical Career Day is the first and most successful "recruiting" venture of SAMA at Marquette, we have a number of other plans on the drawing boards. Primary among these is the high school visitation program which we hope to start in conjunction with the SHO group in Milwaukee. Another hope is to make closer ties with the "pre-med" organizations in the area colleges. We believe that this type of work is one of the most important functions of all medical personnel, to make an effort to find the medical people of the future. If any of you have any suggestions in regard to this type of work, especially if through personal experience; or would like any more information to pass on to someone you would like to see attend the Career Day, please contact us at: SAMA, Marquette Medical School, 561 N. 15th St., Milwaukee, Wis. 53233.—RICHARD P. BARTHEL, Secretary, SAMA, Marquette, Milwaukee.

SPECIAL TO THE JOURNAL

Vietnam Revisited

By VICTOR S. FALK, M.D.
Edgerton, Wisconsin

■ ENROUTE TO VIETNAM our plane landed at Tokyo just as I finished reading *Incredible Victory* which described the confrontation between the Japanese and American navies at the battle of Midway in 1942. Seated next to me on the plane was another American volunteer physician, also bound for Vietnam, who had been a Messerschmidt pilot in the German *Luftwaffe* in World War II. What a strange world we live in! Twenty-five years ago Japan and Germany were our bitter enemies. These nations are now friendly and one wonders what countries will be our allies in another quarter of a century.

The need for medical help from the free world in Vietnam has certainly not diminished in the past year. It is true that there is grossly inadequate medical care in half the world, but the misery in Vietnam is compounded by the great number of civilian war casualties. In the two and one-half years that "Project Viet-Nam" and its successor program called "AMA Volunteer Physicians for Viet Nam" have been in existence, 377 American physicians have gone to Vietnam on a volunteer basis. In the first year there were 119, but none from Wisconsin. In the second year there were 173, seven of whom came from Wisconsin. In the last six months 85 physicians volunteered and four were from Wisconsin. These four were Doctors Thomas Beno, of Green Bay, Leif Lokvam of Kenosha and myself, all general surgeons, and Doctor Isadore Schultz, a general practitioner from Mazomanie. The story of Doctor Schultz is remarkable in that he was born in Russia in 1898 and recently retired from practice. Doctor Lokvam's tour was cut short by "fever of undetermined origin" later complicated by a severe hemolytic reaction to primaquine.

In addition to the volunteers from the United States there were free world medical teams from the Philippines, South Korea, New Zealand, Australia, Nationalist China, Switzerland, Great Britain, Spain, Iran, and Free Cuba. There was also a hospital ship, the HELGOLAND, from West Germany, which has been in Vietnam for more than a year.

A report on Doctor Falk's first visit to Vietnam appeared in the February 1967 issue of the WISCONSIN MEDICAL JOURNAL. Each tour of duty was for 60 days.

Saigon seemed more crowded than ever and indeed its population has increased tenfold in recent years. Unfortunately, the essential utilities have been unable to keep up with this population explosion. Two interesting and encouraging institutions were seen in Saigon, both new this year. The first was the University Medical School, which is in a fine, new building, built with American funds. The medical school has a ten-year contract with the AMA, and many of the faculty members are from the United States. The six-year school has almost 1,200 students and soon will be graduating 200 MDs each year. This in itself is remarkable since there are only 1,000 doctors in the entire country now. About 80% of all physicians are assigned to the Vietnamese military and it is anticipated that the same situation will prevail among the new graduates. Since the young men in Vietnam have a ten-year military commitment, it is obvious that it will be some time before the ratio of physicians to general population will improve. Some of the provinces have no doctors of medicine and others may have two or three for a half-million population. At the present time, only a few of the superior students are assigned to internships. The remainder of the graduating class spends an additional year observing and studying for licensure examinations. However, this next year, more of the graduates will be sent to provincial hospitals for their internships. There they will be under the tutelage of American physicians.

The second new institution in Saigon was the National Rehabilitation Institute. Amputees, paraplegics, the blind, and patients with polio residuals are all treated there. The institute includes a prosthetic shop where all of the employees are themselves amputees. There also are branches in Can Tho and Da Nang. Technical and financial assistance is received from the World Rehabilitation Fund.

My assignment this year again was to Vinh Binh in the Mekong Delta. Consequently, it was possible to make comparisons and to look for signs of progress. I was more prepared for the initial impact of sights and smells, but the hospital was definitely

The new University of Saigon Medical School which opened December 1966. (Recently reported to be "occupied by friendly troops.")

Mr. Liem, Chief O.R. Nurse, with ancient Percy retractor . . .

. . . used in amputations which unfortunately were frequent.

cleaner. There was less livestock about the hospital compound and finally this diminished to just a small herd of goats. These were more agile in getting about the hospital and since they belonged to the *Medecin Chef* they enjoyed some degree of status. At first there appeared to be fewer war casualties in the hospital than last year, but this situation rapidly changed and there soon were more than ever. In talking with my colleagues later, the casualty rate apparently increased throughout the country late in 1967.

The province had been given a complete one-hundred bed emergency hospital unit by the Canadian government. Some of the equipment was sent out to the district dispensaries and maternity hospitals for the aid men and midwives to use. Notable additions in equipment included an operating table which could be positioned rather than the old model which was at a fixed level, two ether machines, and a second autoclave. The x-ray unit was moved from its location about a block away from the hospital to a remodeled space adjacent to surgery. The water supply was still limited and contaminated. One small sink had been installed in each ward but as yet not attached to any system. A deep well had been in the process of being dug for over six months and some of the water pipes were entrenched while I was there. The electricity was still somewhat erratic and the independent generator for the hospital, which had been brought in a year before, still was not in operation. There were six new Simmons hospital beds in the recovery room but the beds in the wards consisted simply of boards covered with thin straw mats. Because of the crowded conditions it was not unusual to have two or three patients in a single bed.

Fortunately blood for transfusion was generally available this year. This was from U. S. sources and was turned over to us about the time it would be outdated. In the past, blood was usually in short supply because the Vietnamese are generally anemic and frequently reluctant to donate blood.

The military casualties were not cared for at our hospital but the number and scope of civilian casualties continued at a rate simply not comprehended by Americans. Here are a few memorable examples: a 16-year-old boy with a single, small bullet wound of the neck which transected his cervical cord and resulted in quadraplegia; a 17-year-old girl with a loss of the mid-portion of her clavicle and underlying brachial plexus; several elderly women with compound jaw fractures; many gunshot wounds of the abdomen resulting in perforations of bowel, stomach, liver or spleen; many chest wounds treated by drainage; a 4-year-old with a fragment wound extending through the scrotum, bladder and descending colon; jagged-edged fragments penetrating the neck and lodging in the trachea or larynx. A 10-year-old girl was brought

Ten-year-old girl who had fore-quarter amputation following shoulder wound.

Ten-year-old girl with gun shot wound of the abdomen. The rice-bowl was covering eviscerated bowel. (She also had a lacerated liver, but survived.)

in with a rice bowl strapped to her abdomen. When the rice bowl was removed, she was found to have a gunshot wound of the abdomen resulting in evisceration of small bowel and an extensive laceration of the liver. Leg amputations were unfortunately all too common. Most of these were in women or young people who had encountered Viet Cong booby-traps in rice paddies. These resulted in mangling foot injuries which could be treated only by amputation. This type of wound was particularly distressing, accomplished absolutely nothing militarily, and was simply another example of the Viet Cong terrorism. At no time did I ever see a single case of napalm burn. Despite the severity of the war wounds, the patient survival rate was remarkably high.

There was also a perpetual backlog of elective surgery waiting to be done when there was a lull in casualties. Goiters in women were extremely prevalent, and on one day four patients came in with this condition. Fortunately, toxicity was rare. Uterine prolapse was also common and usually total. One patient with third degree uterine prolapse was also found to be four and one-half months pregnant. Many malignant tumors of the mouth were seen. These were all in women and were attributed to the prolonged chewing of betel nuts. Secondary closures of gunshot wounds and skin grafting were also frequently scheduled. Patients with huge, deep abscesses and osteomyelitis often came to surgery. Several casualties resulted from gorings by water buffalo. Since circumcision of the newborn is never practiced, there were numerous young boys with paraphimosis who were initially treated by dorsal slit. One 4-year-old was found to have small bowel obstruction and perforation due to round worm infestation (Ascariasis).

Cesarean sections were done because of complications encountered by the midwives. One patient was 51 years old. The incidence of ruptured tubal pregnancies seemed unusually high. Every patient with appendicitis was found to have a ruptured appendix. Small bowel perforations due to typhoid were also encountered.

A new source of nonmilitary casualties resulted from the popularity of motorcycles. The drivers were untrained and there was absolutely no traffic control. On one occasion five patients were brought in from a single motorcycle accident. A confrontation involving a Honda and a Suzuki resulted in real carnage.

Problems in pediatrics were phenomenal. Children would come in with hematocrit readings as low as 3 to 6 per cent. A stool survey showed a high incidence of hookworm infestation and Ascariasis seemed almost universal. Diphtheria, whooping cough, and tetanus were also encountered. The residuals of polio were often seen. Tuberculosis in all age groups affected a high percentage of the total population. Consequently such complications as scrofula, Pott's disease, and psoas abscesses often turned up in the surgery wards. Only one patient with leprosy was seen but there are three leper colonies in Vietnam.

"Intensive care ward."

This patient delivered while convalescing from severe leg wound. Note kerosene stove and kettle in her bed.

The results of treatment by the local Chinese and Cambodian practitioners were obvious. One 4-year-old child came in with both eyes completely destroyed after using drops given by a Chinese "doctor." All the patients with goiters had previously had their necks nicked and excoriated. One woman I had in my surgical ward was treated by the Chinese practitioner who made several hundred small incisions in the skin of her lower extremity while she was a patient in the hospital. Suction cups are widely used in the treatment of respiratory infections and headaches. These leave large, red welts wherever they are applied.

The patient's hospital charts continued to be interesting, with a smattering of three languages. I am sure our attempts at French and Vietnamese were amusing. When the Vietnamese attempted to Anglicize their reports, a description of a gunshot wound of the abdomen appeared as "one hool of the liver and one hool of the stomac." Almost all patients admitted to the hospital were automatically given

With Governor Knowles in Bangkok, Thailand, the day after leaving Vietnam. (The Governor was leading the Wisconsin Trade Development Mission to the Far East.)

an injection of camphor and Niketamide if they were seen by the Vietnamese staff first. Relationships with our Vietnamese counterparts were generally cordial. However, the number of Vietnamese was inadequate to man a hospital of this size even if there were not a war going on. Fortunately the hospital staff was bolstered by three American civilian nurses and an Air Force team consisting of four medical officers, one medical administrative officer, and ten enlisted men.

The two and a half hour noon day siesta continued unaltered. This was violated on only one occasion in two months when an especially large number of casualties arrived at the hospital late in the morning. Otherwise all activity ceased at noon as it did on Saturday afternoon and Sundays except for emergencies. However, it seemed that the casualty rate was always much greater on weekends.

My conclusions at the end of this second tour are essentially the same as they were a year ago. We Americans are deeply committed in Vietnam, both militarily and medically. Even the gentlest doves among the young American doctors who were not volunteers agreed that continued American support was necessary. Even if the war were to end, the need for medical assistance would continue, especially in the fields of training Vietnamese doctors, nurses, and technicians. Once an area is pacified and secure, a program of basic sanitation can be inaugurated. The same is true of grand scale immunizations which could eliminate the problems of smallpox, diphtheria, whooping cough, measles, and polio.

Thus it appears that the program for volunteer physicians will need to be continued indefinitely. This program has multiple psychological impacts. The first, of course, is on the Vietnamese, who do appreciate our medical contribution. It is amazing how rapidly the people learn of the American doctors' presence and of the fact that they are serving voluntarily and without pay. The second impact is on the people in our own communities in the United States. Although it may not make the war in Vietnam any more popular with them, it is somewhat more acceptable and they do seem to have a better understanding after hearing the reports of the volunteers. In the past year I have received over $2000 in unsolicited contributions to be used for the hospital and orphanage at Vinh Binh. Another surprising impact of our presence as older civilian volunteers in Vietnam is on the American military. Many of the younger enlisted men and the older career officers were heartened by this as they had begun to have some doubts about patriotism and support from their own countrymen.

AMA Volunteer Physicians for Vietnam

AMA Volunteer Physicians for Viet Nam is administered by the American Medical Association, under contract, for the United States Agency for International Development. It is a program designed to use the volunteer services of U. S. physicians to assist in meeting the health needs of the Vietnamese civilian population.

The program was an outgrowth of a request by the Vietnamese government to the U. S. government to help obtain the volunteer assistance of the U. S. medical profession. Under the impact of 25 years of war, health services in South Viet Nam had become inadequate to maintain the health of the people. Of the 1,200 Vietnamese physicians, for example, nearly 800 are in military service and unavailable for full time civilian practice.

About 50,000 Vietnamese civilians are treated in hospitals annually for war-related injuries. Major diseases of South Viet Nam include tuberculosis, typhoid, cholera, plague, intestinal parasitism, and infectious diarrheas among children. Primarily to the high disease incidence, the life expectancy of the Vietnamese male is said to be 35 years.

A continuing need exists for volunteer physicians. Particularly needed are general surgeons, orthopedic surgeons, general practitioners and internists. Other specialists are needed from time to time.

Interested physicians should contact:

Director
AMA Volunteer Physicians for Viet Nam
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

the wisconsin medical journal

VOLUME 67/NUMBER 5 MAY 1968

Pemphigus, Pemphigoid, or Dermatitis Herpetiformis?

By HAROLD O. PERRY, M. D., Rochester, Minnesota

■ THE SPECIFIC DIAGNOSIS in a generalized blistering eruption depends on proper evaluation of a combination of factors. These include the clinical history, morphology of the cutaneous lesions, the histopathologic findings of the skin biopsy, and the results of therapy. The results of standard routine laboratory tests are of little differential diagnostic value. Thus, it is best to withhold a specific diagnosis until the bulk of evidence favors one or the other of these diagnoses.

This uncertainty regarding the specific clinical diagnosis of a bullous eruption has been exemplified by Schneidman[1] who, in discussing a case of bullous pemphigoid, stated:

> We've seen several cases of the same category where at times this eruption appears to be pemphigus, and at times pemphigoid, and at times appears to be dermatitis herpetiformis. We have given sulfapyridine and the other related drugs, and they have helped for a few days, apparently decreasing the infectious component of the disorder. I think that whenever steroids are given they change the complexion of the disease, whether it be pemphigus or pemphigoid, and that these cases apparently aren't pemphigus but are in the pemphigoid group.

Slepyan and Rodin,[2] in discussing the bullous dermatoses, emphasized the nonspecificity of the clinical pattern of these entities and remarked that even some of the "Old Masters" of dermatologic diagnosis had noted the change in clinical picture from one examination to the next. Slepyan also emphasized the confusion regarding histologic alteration in these diseases and stated that acantholytic cells can be found in diseases other than pemphigus.

Very early, pemphigus was recognized as a serious disease that eventually led to death; but it was realized that other blistering diseases which, although closely resembling pemphigus clinically, were without its lethal outcome. The name "parapemphigus" was early given to this second group of diseases. Subsequently, it was Duhring,[3] an American dermatologist, who applied the name "dermatitis herpetiformis" to those generalized blistering eruptions in which grouped lesions (vesicles, urticarial papules, or even pustules) are symmetrically distributed over the scalp, scapulae, axillary areas, trochanteric prominences, and the sacral region. Although at times erythema multiforme was confused with this group, the target or iris lesions of this entity seemed to separate and make it a distinct clinical disease.

Some patients with generalized blistering eruptions had neither pemphigus nor dermatitis herpetiformis even though, morphologically, they may have been considered to have atypical forms of either.[4, 5] In the past, these eruptions were generally referred to as "benign blistering in the aged" because the

From Mayo Clinic and Mayo Foundation, Section of Dermatology.

Presented at the 126th Annual Meeting of the State Medical Society of Wisconsin, May 11, 1967, Milwaukee.

Reprint requests to: Section of Publications, Mayo Clinic, Rochester, Minn. 55901.

older age group was most often affected. This same confusion also was applicable to the generalized blistering eruptions in children. Subsequently, this disease became known as "generalized bullous pemphigoid."[6] Some patients with localized, scarring herpetiform plaques may at times have generalized blistering eruptions that resemble dermatitis herpetiformis.[7] The exact nosologic position of this entity remaius unclear.

The histopathologic changes in each of these diseases seem distinct. In pemphigus vulgaris,[4] the acantholytic process with acantholytic cells in a suprabasilar position of the epidermis is representative of the disease. In dermatitis herpetiformis, the papillary bodies are stuffed with acute inflammatory cells, giving rise to a subepidermal vesicle; this is distinctive and affords a means of differentiation.[8] Bullous pemphigoid, however, shows a subepidermal vesicle that seems to be produced by marked edema of the dermis, resulting in separation of the overlying epidermis. Michelson,[9] in discussing a patient with pemphigus foliaceus, questioned the specificity of acantholysis in the histopathologic diagnosis of pemphigus. Fisher[10] earlier had emphasized his inability to find constant histopathologic changes in patients with pemphigus vulgaris. As recently as March 1967, editorial comments on the histology of vesicles place the blistering of dermatitis herpetiformis and pemphigus in the same general group.[11]

Electron microscopic studies of pemphigus vulgaris,[12] pemphigoid,[13] and erythema multiforme[14] present findings that can separate pemphigus vulgaris from the other blistering diseases. The essential electron microscopic changes that progressively appear in pemphigus vulgaris apparently consist of (1) loss of attachment of tonofilaments to the desmosomes, (2) clumping of the tonofilaments in the paranuclear area, and (3) finally, separation of epidermal cells by the splitting of the attachment plates. The hemidesmosomes are unaffected, thus accounting for the suprabasilar vesicle formation seen in light microscopy. In contrast, pemphigoid apparently begins as a dermal process with edema formation that successively involves the dermis, epidermis, and the basement membrane. The edema involves the epidermis, forming an intra-epidermal vesicle in which epidermal cells serve as the roof of the vesicle, and the basement membrane, which is attached to the dermis, furnishes the floor.

Michalowski[15] described electron microscopic findings in three biopsy specimens of dermatitis herpetiformis that were similar to those of pemphigus vulgaris, namely, alteration of the tonofilament-desmosome complex that resulted in the partial acantholysis of epidermal cells. In addition, the number of mitochondria in the cells was diminished. The primary alteration probably occurred in the tonofilaments.

A further differentiation of pemphigus, pemphigoid, and dermatitis herpetiformis occurs when skin biopsy specimens are studied by means of immunofluorescent techniques that involve the sera from patients with these diseases.[16, 17] In these studies, immunofluorescence occurred in an intercellular position in pemphigus vulgaris and in the basement membrane in dermatitis herpetiformis. There was a complete absence of fluorescence in pemphigoid.

Patients with dermatitis herpetiformis suffer only from the local distress produced by the disease. Before steroids were available, patients with pemphigus vulgaris suffered from generalized debility secondary to the blistering and eventually died. Now with steroid therapy the patient survives his disease but dies of complications from the treatment.[18–20] General physical evaluation sometimes reveals an underlying malignancy in patients with bullous pemphigoid.[21]

The systemic administration of sulfapyridine has almost become specific for dermatitis herpetiformis, and some believe that resolution of a blistering eruption with the administration of this drug is clinical confirmation of this diagnosis. In my experience, patients with pemphigus vulgaris do not show a response to this drug although exceptions have been noted.[22] In some patients with bullous pemphigoid, blistering may resolve with sulfapyridine therapy. Adrenocorticosteroids are most effective in suppressing the blistering of pemphigus vulgaris, but they are not as frequently effective in the management of pemphigoid. In my experience, these drugs are of no use in the management of dermatitis herpetiformis.[23]

The following case reports demonstrate the various clinical manifestations of these blistering eruptions, as well as the histopathologic findings, laboratory test results, and therapeutic approaches that are employed in an effort to differentiate these diseases.

Fig. 1—(Case 1) *A*, Generalized bullous eruption present in a 5-year-old girl. *B*, Vesicles can be seen atop or along margins or urticarial plaques, suggestive of dermatitis herpetiformis.

Report of Cases

Case 1.—A 5-year-old girl was seen during January 1967 with a blistering eruption that had been present for more than 1 year (since November 1965). Red macular patches began on her abdomen, after which small blisters developed along the margins of these plaques. The eruption eventually spread over all the skin except for the mucous membranes. The girl has had sore throats occasionally, and cultures on many of these occasions indicated *Streptococcus*. She has not, however, had a sore throat for almost a year. The parents could not relate the eruption to foods for seasonal variation. There were no unusual family childhood illnesses.

On examination, a generalized but grouped symmetric eruption of the vesicobullous lesions was seen on an urticarial base (Fig 1). Blisters varied in size but generally were 2 to 4 mm in diameter. Depigmentation was present in previously involved areas, but there was no atrophy of the skin. The clinical impression was that of bullous pemphigoid of childhood (dermatitis herpetiformis), but a slide of a biopsy specimen taken at another institution and accompanying the patient showed the changes of pemphigus foliaceus (Fig 2 A). However, on the basis of the clinical impression, therapy was started with sulfapyridine, 5 grains three times daily, and with elixir of diphenhydramine (Benadryl), 10.0 ml three times daily. The dosage was increased 48 hours later to 5 grains four times daily, and the skin cleared.

Results of laboratory tests were as follows: urinalysis, normal; hemoglobin value, 11.3 gm/100 ml; leukocyte count, 7,000/cu mm with 9% eosinophils; and serum-protein electrophoresis and chest roentgenogram, normal. A skin biopsy from the right arm done at our clinic showed a subepidermal inflammatory reaction of epidermal cells filled with polymorphonuclear leukocytes and eosinophils, findings that are consistent with the histopathologic changes of dermatitis herpetiformis (Fig 2 B).

COMMENT.—This 5-year-old girl had an eruption considered clinically as either bullous pemphigoid or dermatitis herpetiformis. Skin biopsy specimens showed histologic changes of pemphigus foliaceus on one occasion and consistent with dermatitis herpetiformis on another, and there was a satisfactory response to sulfapyridine. Our final diagnosis was dermatitis herpetiformis.

Case 2.—An 18-year-old boy with a 2 months' history of an erosive process of the gums was first seen during August 1966. Later, he noted crusts and scaling over the anterior region of his chest, but there were no blisters. Clinically, the eruption was interpreted as an impetigo. There was no response to the topical use of an antibiotic ointment; more cutaneous lesions developed, and the mouth lesions became worse. During August, blisters erupted about the previous crusts and on the normal skin of the chest, back, and face. A skin biopsy was done, and a diagnosis of pemphigus vulgaris was made (Fig 3). The patient was referred to our clinic for further care.

Because of his widespread skin eruption (Fig 4), the patient was hospitalized and steroid therapy was started. An initial dosage of 60 mg of prednisone daily was required in four equally divided doses to

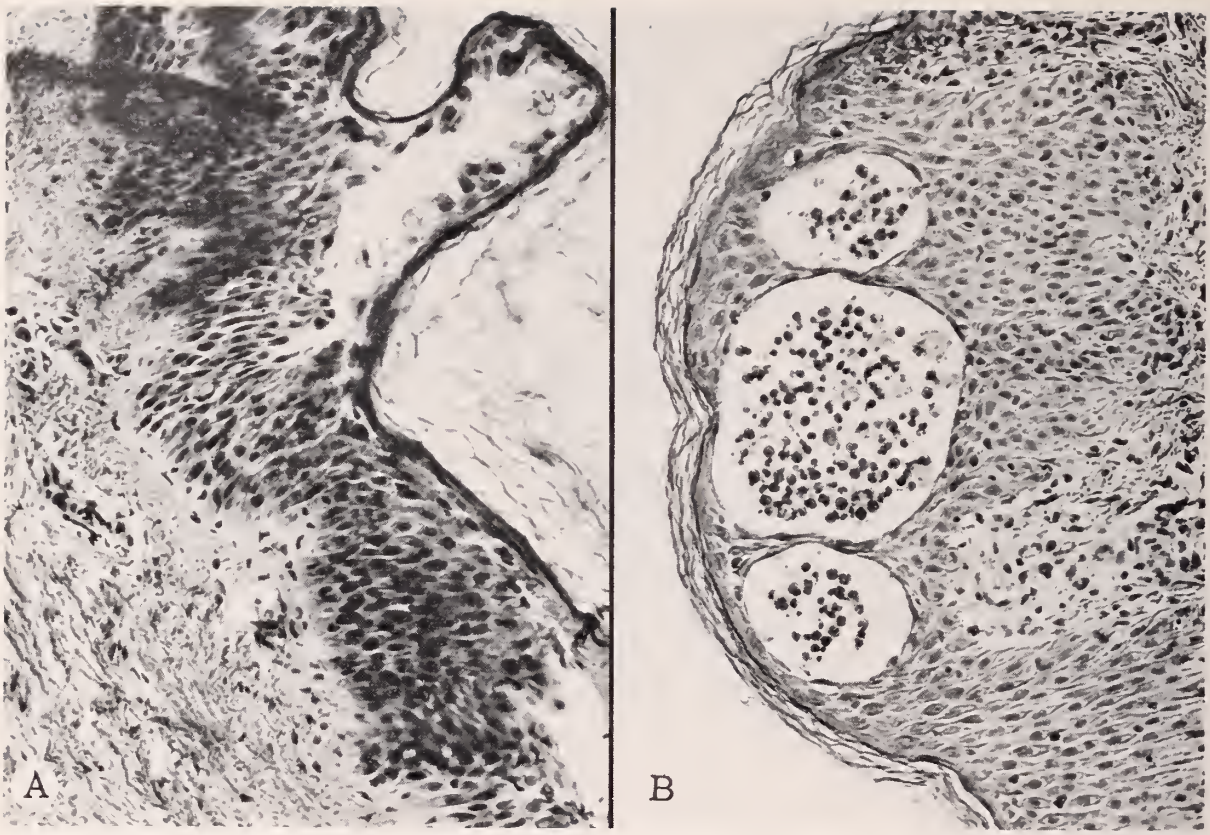

Fig. 2—(Case 1) *A*, Biopsy specimen taken at another institution. Bullous formation high within epidermis is suggestive of the diagnosis of pemphigus foliaceus. (Hematoxylin and eosin; x200) B, Biopsy specimen taken at Mayo Clinic. Presence of polymorphonuclear cells within epidermis associated with inflammatory reaction in upper corium was considered unusual for diagnosis of dermatitis herpetiformis. (Hematoxylin and eosin; x190)

suppress the reaction; subsequently, 40 mg per day was sufficient to maintain suppression of the blistering.

During the subsequent 9 months, regular follow-up has indicated that the patient developed the usual stigmata of hypercortisonism with the rounded facies, hirsutism, and acne in addition to a minimal degree of hypertension. The acne is being managed by a 2-gm sodium diet and increased sedation.

During the time steroid reduction was attempted, the patient experienced a worsening of his skin reaction. Medication was changed to betamethasone (Celestone), with control of the eruption. Quickly, however, muscle weakness, mainly of the legs, developed to a degree that made walking impossible. For this reason, steroid therapy was changed back to prednisone, and after 2½ months, the muscle weakness is no longer a problem and the patient has gone back to a full program of activity. At the present time, his dosage of prednisone is 32.5 mg per day, with control of the pemphigus vulgaris both of the skin and mucous membranes.

COMMENT.—This patient is rather young to have pemphigus vulgaris; yet even younger individuals have been reported with this disease. If the oral and cutaneous lesions were considered part of the same disease, then one would have to consider one of the more serious blistering eruptions rather than impetigo. Skin biopsy was definitive in establishing the diagnosis.

Case 3.—A 65-year-old farmer was seen during April 1966. During the previous 2 to 3 years, he had noted that he tired more readily from an ordinary day's work than was true theretofore, but he attributed it only to advancing age. In November 1965, he had the onset of chills and shivers, but there was no fever. These disappeared without therapy, only to be replaced by pain in the right upper quadrant that was unassociated with nausea or vomiting. He also noticed gaseous distention of the bowel and a marked decrease in appetite. His personal physician believed that he had hepatitis and treated him with various medications until January 1966.

At the end of November 1965, a macular erythematous eruption developed on the abdomen, chest, and lower extremities. In December 1965, vesicles and bullae developed around the neck and in both axillae and spread to the groin, scrotum, buttocks and, subsequently, to the dorsa of the feet, knees, elbows, and trunk. Occasionally, the patient had a few lesions in the mouth.

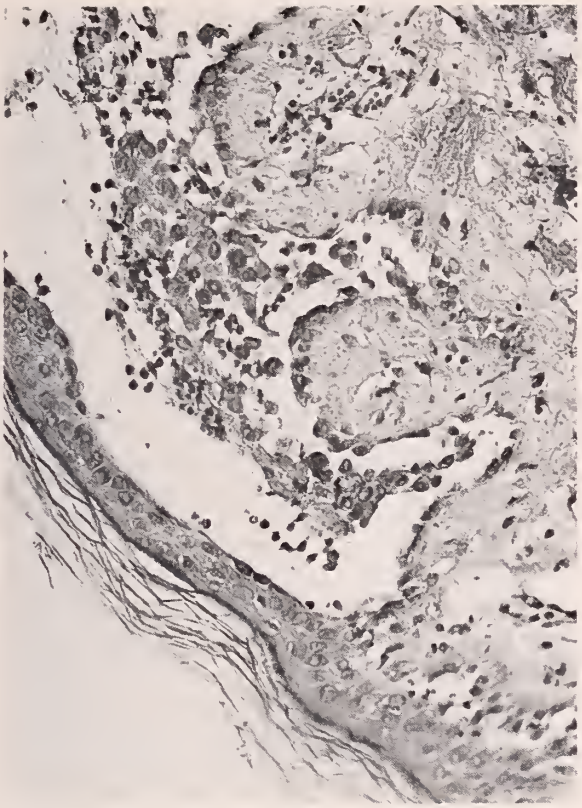

Fig. 3—(Case 2) Presence of acantholytic cells in suprabasilar villi confirmed diagnosis of pemphigus vulgaris. (Hematoxylin and eosin; x225)

In January 1966, a dermatologist diagnosed pemphigus and prescribed prednisone, which produced some involution of the lesions. During this time, because new blisters continued to develop, the dosage of the drug was increased. While taking these pills, the patient had marked thirst, polydipsia, and polyuria. There was no family history of diabetes.

Examination of the patient's skin revealed large violaceous, hyperpigmented infiltrated plaques on the elbows, knees, and dorsa of the feet. One 0.5-cm bulla was present on the dorsum of the right foot, and scattered lesions appeared on the trunk (Fig 5 A). There was marked generalized lymphadenopathy, particularly of the right supraclavicular region and the left axilla. The liver was palpable 2 inches below the costal margin.

Urinalysis revealed glycosuria (grade 4) and no acetone. The value for blood sugar (nonfasting) was 297 mg. A biopsy of the lesions of the right foot showed subepidermal bulla that seemed to progress intraepidermally (Fig 5 B).

The 20 mg per day of prednisone that the patient had been receiving failed to control the blistering eruption. A second skin biopsy was interpreted as consistent with erythema multiforme.

Additional studies were done. Findings on a chest roentgenogram were normal as were those on a peripheral smear and a bone-marrow aspiration.

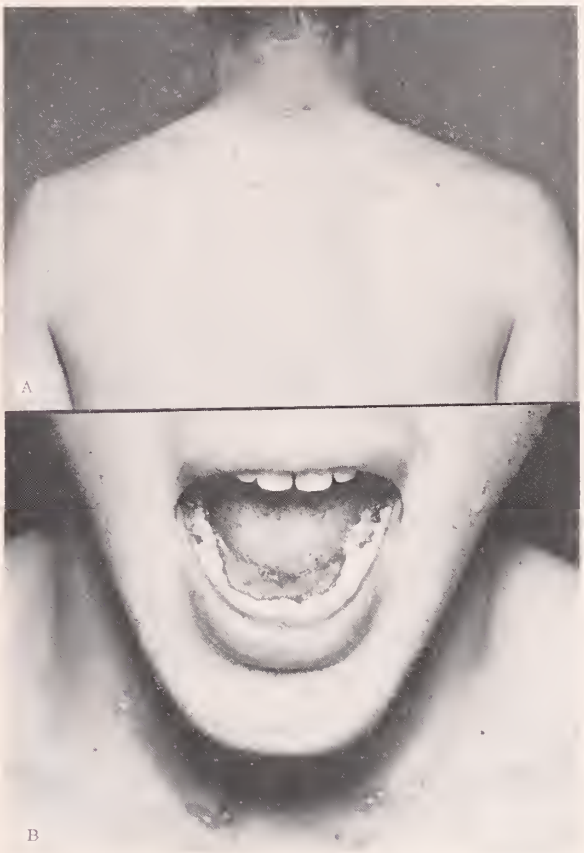

Fig. 4—(Case 2) *A*, Crusted lesions were present as evidence of previous blistering on skin. *B*, Oral lesions consisted of ulcers on floor of mouth.

Biopsy specimen from a node of the left axilla revealed lymphocytic lymphoma. A lymphangiogram showed that the lower left iliac nodes were slightly enlarged, and the architecture was suggestive but not diagnostic of involvement with lymphoma.

COMMENT.—A patient, middle-aged or older, who has a mucocutaneous blistering eruption is a prime suspect for having pemphigus, but in the case reported herein, skin biopsy failed to confirm this suspicion.

Perhaps more emphasis should have been placed on the patient's history of fatigue, which antedated his skin eruption by 3 years. Appropriate laboratory evaluation confirmed the diagnosis of lymphoma.

This patient was considered to have bullous pemphigoid.

Summary

Generalized blistering eruptions representing pemphigus, pemphigoid, or dermatitis herpetiformis may present with such varied patterns and findings that diagnosis is most difficult. The physician must consider the pa-

Fig. 5—(Case 3) A, Variously sized bullae were present over the body. B, Subepidermal bulla was present. (Hematoxylin and eosin; x200)

tient's history, clinical features of the disease, histopathologic and general laboratory findings, and the results achieved by various therapeutic agents in deciding on a specific diagnosis. Despite all available knowledge, a difference of opinion may still exist as to the specific diagnosis.

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MEDICAL HISTORY FEATURE

CYCLOPROPANE

The Early Days at Wisconsin

By HOWARD P. GUTGESELL, JR., Madison, Wisconsin

■ AT A MEETING of the Canadian Medical Association on June 21, 1929, Professor Velyien Henderson of the University of Toronto reported for the first time the anesthetic properties of cyclopropane, a gas which had been prepared by his colleague, Dr. George Lucas. Among those present in the audience that day were Dr. Harold Griffith of Montreal and Dr. Ralph Waters, chief of Anesthesiology at the University of Wisconsin Medical School. In reminiscing on this early and fortuitous meeting, Doctor Griffith remarked, "I was a very young man and perhaps not so conversant with all of the implications which this paper contained, but Doctor Waters immediately was greatly interested because he could see that here was something for which we had been waiting a long time."[1] Doctor Waters was interested indeed, and the trip to Montreal thus became the original impetus for an intensive clinical and pharmacological investigation of cyclopropane at the University of Wisconsin. Besides its historical interest, this investigation can be studied as a model for the introduction of any new drug into clinical usage.

At the University of Wisconsin, Doctor Waters had at his disposal the personnel and facilities for a thorough study of this new anesthetic agent. Besides the staff in Anesthesiology, he had the cooperation of Dr. Walter Meek, chairman of the Department of Physiology and noted authority on cardiac physiology, and of Dr. M. H. Seevers and his colleagues in the Department of Pharmacology.

The first step was to obtain a supply of cyclopropane of reasonable purity. Doctor Waters had been corresponding with Doctor Henderson, and the latter suggested that cyclopropane might be obtained through the Ohio Chemical and Manufacturing Company. On July 8, 1930, Doctor Waters wrote to Ohio Chemical for the price of a small quantity of the gas, and on July 21 he ordered one 10-gallon tank at a cost of $16.00, plus $5.00 for the tank itself.

When the tank arrived, the cyclopropane was first used to anesthetize a dog. Observing no harmful effects, Doctor Waters decided to proceed to the operating room. (Unless it be assumed that this was an overhasty decision, it must be pointed out that Doctor Henderson and his staff had by now tested cyclopropane on subjects ranging from rabbits to Dr. Fredrick Banting himself and had observed no toxic effects, a fact of which Doctor Waters was undoubtedly aware.)

On Aug. 19, 1930, with Dr. E. R. Schmidt the surgeon and Doctor Waters the anesthetist, the first operation was performed on a patient anesthetized with cyclopropane. The operation, an appendectomy, went smoothly and was completed in 35 minutes. On the two succeeding days, cyclopropane was used during the repair of an inguinal hernia and the removal of a gallbladder. At this point Doctor Waters' supply of cyclopropane was exhausted, and the Ohio Chemical Company informed him that they would not be making any more until sometime later that fall.

Doctor Waters was quick to report his progress to Doctor Henderson, and his first letter, uncovered many years later by Doctor Lucas in the files of Toronto General Hospital, reveals that he had already noted many of the advantages ("lack of respiratory stimulation even during induction," "blood pressure variations . . . surprisingly stable"), and the disadvantages ("some tendency to arrhythmia") of cyclopropane. Thirty-five years of research have only served to confirm the wisdom of Doctor Waters' early observation that "the arrhythmia . . . was an indication for more oxygen."[2]

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Lucas and Henderson had reported that the concentration of cyclopropane necessary to produce anesthesia was 12 to 14%. Doctor Waters was somewhat surprised, therefore, when he analyzed the contents of the anesthesia bag at the end of his first three cases and found the cyclopropane content in excess of 40%. Doctor Henderson readily detected the source of discrepancy: Waters had merely added the carbon dioxide and oxygen concentration and subtracted the sum from 100, assuming that the remainder of the gas in the bag was cyclopropane. Doctor Henderson pointed out that the bag probably contained nitrogen and other gases as well as cyclopropane, and he recommended analyzing directly for cyclopropane by absorbing it in strong sulfuric acid. Doctor Waters took his advice, and in his first paper on cyclopropane stated that the gas was an effective anesthetic at a concentration of 20%.

From this point, progress was rather slow. The anesthesia ledger of Wisconsin General Hospital shows that cyclopropane was used for a total of nine operations in 1930, 12 in 1931, and 14 in 1932. There were a number of reasons for this rather meager total. One was a lack of funds. In the present era of abundant federal grants for medical research, it is hard to imagine a project with as much promise as this one suffering from a lack of money, but that was exactly the case. The effects of the Great Depression were felt everywhere, and Doctor Waters had the unenviable task of convincing the hospital authorities to purchase large quantities of this totally unproven gas at a cost of $2.50 a gallon. The drug and chemical companies, meanwhile, were caught on the horns of a dilemma of their own; they too were suffering the effects of the depression, and could ill-afford the losses involved in making small batches of cyclopropane for research purposes. On the other hand, they could hardly afford not to continue, for if cyclopropane should live up to its early expectations and replace ether and ethylene in the operating room, the rewards would be rich indeed. Hanging over this scene was the cloud of possible ruin if cyclopropane would gain an unsavory reputation because of latent toxic effects or accidents due to careless or incompetent usage.

In the spring of 1933, Doctor Waters and his associates decided to put cyclopropane to an intensive clinical trial involving hundreds of patients. Only in this way could they be certain enough of its advantages and its safety to make a public report of its use. It was decided to replace ethylene and ether with cyclopropane for a period of at least three months in order to gain some idea of what to expect if it were put on the general market. By October, at the 12th Annual Congress of Anesthetists in Chicago, Stiles, Neff, Rovenstine and Waters presented their first public report on the clinical use of cyclopropane, based on 447 cases.[3] Referring to the investigation of the anesthetic at Wisconsin and to this first paper, Doctor Griffith stated, "No new drug has ever been given a more comprehensive, intelligent, and conclusive study by any one group of investigators . . . even today this report remains the definitive paper on cyclopropane."[1]

In reviewing the events between the first anesthetization with cyclopropane at Wisconsin in 1930 and the first public report in 1933, one is stuck by the length of the time lag, and by the fact that no one "scooped" Doctor Waters and published an earlier study. Neither of these is due entirely to chance. The time lag, as has been pointed out, was due partly to the very limited supply of both cyclopropane and funds with which to purchase it, and to Doctor Waters' insistence on a thorough trial before making any public statement. Although demonstrations of cyclopropane were occasionally given for visitors, Doctor Waters was on the whole rather quiet about what he was doing until he felt confident that he knew how to manage the gas.

In a letter of July 1934,[4] Doctor Waters explained that one of the reasons that he had held back on the cyclopropane study was that he hoped that someone would come up with an anesthetic which would be noninflammable and still present all the advantages of cyclopropane. Having given up hope that such a drug would appear at that time, he agreed to introduce cyclopropane as "the best possible substitute." One cannot help but wonder how many men would have held back the publicizing of data which would surely enhance their reputation on the hope that someone else would come up with something better.

Physicians other than Doctor Waters had heard and read the early reports of Lucas and Henderson on the anesthetic properties of cyclopropane, and as one might expect,

some were interested in obtaining the gas to try for themselves. This introduced another aspect of drug investigation into the cyclopropane study: the ethical and legal standards which should govern the distribution and use of any agent as potent as cyclopropane. Dr. E. A. Rovenstine, one of Doctor Waters' first residents, relates that Doctor Waters urged the manufacturers to keep cyclopropane off the general market during the early trial period.[1] Then he invited 12 friends (all of whom he considered competent anesthetists) to Madison for a demonstration and instruction session, after which he advised the producers to sell them cyclopropane also.

The anesthetists who used cyclopropane were immediately struck by its potency, and fearful of what might happen if it were used indiscriminately, they also urged restriction of its sale. One might expect that this presented a somewhat ticklish situation, for the manufacturers had to convince inquiring physicians not to dabble with cyclopropane until a definitive study was completed, and do so without implying in any way that the inquirers were not competent anesthetists.

After the presentation of the preliminary clinical reports in October 1933, interest in the new anesthetic grew rapidly. Before the end of that month, Doctor Griffith had begun to use cyclopropane at the Homeopathic Hospital of Montreal, and thus became the first anesthetist in Canada to employ cyclopropane. In 1934 Schmidt and Waters published a second report from Wisconsin, this one covering 2,000 cases.[5] In the same year, the first of a vast number of papers dealing with the physiological and pharmacological effects of cyclopropane was published by Seevers, Meek, Rovenstine, and Stiles.[6] This comprehensive work, prepared by a pharmacologist, a physiologist, and two anesthesiologists, is an excellent example of the harmony between the basic and clinical sciences which characterized the study of cyclopropane at Madison.

No report on cyclopropane would be complete without mention of its effect on cardiac automaticity. In their experimental animals Lucas and Henderson had noticed irregularities on the blood pressure tracings which they interpreted as dropped beats. Doctor Waters also had observed occasional cardiac irregularities in his clinical experiments. Since the Seevers report had shown that cardiac arrhythmias were frequent in dogs at high concentrations of cyclopropane, Kurtz, Bennett, and Shapiro[7] began an investigation on the occurrence of cardiac irregularities during various surgical procedures. Their study revealed that cardiac irregularities were more common in clinical practice than generally supposed, and that the clinical experience with cyclopropane was not essentially different from that already related for animals. The irregularities discussed so far occurred under very deep levels of anesthesia. In order to assess the effects of lighter levels, Meek, Hathaway, and Orth[8] compared the effects of challenging doses of epinephrine on dogs anesthetized with ether, chloroform and cyclopropane. Their conclusion, rigidly followed until very recently, was that the use of epinephrine or other catecholamines is strongly contraindicated in cyclopropane anesthesia.

In 1935 the research effort was aided considerably by a grant from the firm of E. R. Squibb and Sons. The grant, which was renewed the following two years, was used to establish a student fellowship and to purchase, among other things, an electrocardiograph unit to be used by Doctor Meek in his study of the effects of cyclopropane on the heart. The House of Squibb had begun to manufacture cyclopropane and wished to establish a relationship which would benefit both it and the University research program. Needless to say, the funds were greatly appreciated.

As research continued in the laboratories, the popularity of cyclopropane in the operating room at Wisconsin was reflected in its frequent use. In 1933, it was used in 860 cases (22.4% of all anesthetizations). This figure rose to 2,343 (56.7%) in 1934, and after a peak of 61.7% in 1935, its use leveled off at about 50% of all anesthetizations for the rest of the decade. By 1944, cyclopropane had been used as the major agent to anesthetize nearly 25,000 patients in Wisconsin General Hospital. In summing up these cases, Doctor Waters writes, "My experience of nearly 15 years with cyclopropane leaves me with the personal impression that this agent permits rapidity of control of the depth of anesthesia impossible with other inhalation agents. However, this very fact may result in unfortunate and disastrous results

when ignorance or carelessness accompany the administration."[9]

Although cyclopropane may in time be replaced by newer anesthetics with more advantages and fewer side effects, the principles which guided its introduction to clinical use at the University of Wisconsin will remain the same. Before any anesthetic can be released on the commercial market, it must be thoroughly tested, first on laboratory animals, then, under carefully controlled conditions, in clinical experiments. And even after the dosages, side effects, and the contraindications are well established, it must be remembered that even the safest anesthetic can be lethal in the hands of a careless or untrained anesthetist.

ACKNOWLEDGMENTS: The author is indebted to Dr. Q. R. Murphy, Department of Physiology, and Drs. Betty Bamforth and K. L. Siebecker, Department of Anesthesiology, for assistance in preparing this paper, and to Dr. Nicholas Mani, Department of History of Medicine, for reviewing the manuscript.

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Hemophilus Influenzae Meningitis

Report of a Case in an Adult Due to a Nontypable Organism

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■ HEMOPHILUS INFLUENZAE meningitis is a fairly rare infection in the adult.[1-4] Snyder and Brunjes reported that only 1.7% of their 1,094 cases at Los Angeles County Hospital were in adults. Their 18 adult cases brought the world total to 79 by 1965. The majority of reported cases has been due to Hemophilus influenzae type B and, in contrast with childhood illness, many adult cases have complicating factors which have altered their resistance to infection. The present case is unique in that the patient had previously had meningitis as a child and the causative agent of the second attack was nontypable.

Case Report

A 30-year-old man was admitted to the hospital on Dec. 19, 1965. He had had an upper respiratory infection during the preceding week, and had been started on erythromycin therapy for a suspected acute sinusitis two days before admission. On the day prior to admission he was well enough to go to a party. On the day of admission he had a severe headache which did not respond to codeine. He had chills, nausea, and vomiting.

His history was important because of a previous hospitalization at age 9 for what was assumed to be a meningococcal meningitis, although sulfonamide therapy preceded the culture, and bacteriologic proof was not obtained.

On examination he was oriented and acutely ill. He had shaking chills, a temperature of 102.8 F and nuchal rigidity. There were no lateralizing neurologic findings. His heart and lungs were clear. His eardrums were normal. There was a watery nasal discharge which was negative for sugar on Labstix* testing. The lumbar puncture yielded a cloudy fluid under a pressure of 240 mm of water. There were 8,000 white blood cells in the cerebrospinal fluid (CSF) with 97% polymorphonuclear leukocytes. The CSF sugar was 29 mg/100 ml and the protein was 252 mg/100 ml. The Gram stain of the CSF showed no organisms. The initial white blood cell count was 17,000/cu mm with a differential count of 82 polymorphonuclear leukocytes, 14 bands, 3 lymphocytes and 1 eosinophil. A nontyp-

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* Labstix® Reagent Strips, Ames Company, Inc.

able Hemophilus influenzae was recovered in CSF culture.**

Initial therapy included 4 gm of sulfisoxazole (Gantrisin), 12 million units of penicillin G, and 2 gm of chloramphenicol intravenously per day. Meperidine hydrochloride (Demerol) was required to control his neadache. On the second hospital day his only complaint was of headache over the right eye. There was some nystagmus on left lateral gaze. No other distinct neurologic asymmetries were noted by the consulting neurologist. X-ray films of the skull were normal except for some clouding of the right ethmoid cells. Penicillin and sulfisoxazole were discontinued on the third hospital day while the intravenous chloramphenicol was continued. Chloramphenicol, 4 gm orally per day, was started on the sixth hospital day and reduced to 2 gm a day from the ninth through the fifteenth hospital days. By the fourth day his neck was supple. His temperature dropped after admission, and was not above 100.2 F for the first five days, and was normal thereafter. After the third hospital day his general and neurologic findings remained normal except for some depression of the light and accommodatory pupillary reactions of the right eye as late as the sixth day. The serum iron was 63 mcg/100 ml on the fourth day, and 170 mcg/100 ml on the ninth day, and the total iron-binding capacity was 260 mcg/100 ml on the fourth day, and 327 mcg/100 ml on the ninth day. His hemoglobin level was 12.7 gm/100 ml on admission, and 14.6 gm/100 ml on discharge. It was 13.6 gm/100 ml and 13.8 gm/100 ml the first and second weeks after discharge. He returned to work one month after admission and has remained well.

Discussion

It already has been stated that Hemophilus influenzae meningitis in adults is relatively rare. Snyder and Brunjes in their review state that the true incidence of Hemophilus influenzae meningitis in adults as compared to children cannot readily be determined from the literature because the adult cases tend to be reported more often, due to their rarity.[1] Records of all the cases of Hemophilus influenzae meningitis at Madison General Hospital during the period 1958 to 1965 were reviewed. Thirty-eight cases were found, ranging in age from a few months to three and one-half years. There were 12 females and 26 males. No older pediatric and no adult cases were found. The rarity of this infection in adults has been ascribed by many authors to the theory of humoral immunity increasing with age as reported by Fothergill.[5] Hemophilus influenzae is a normal inhabitant of the adult respiratory tract, but in the rough form, not the typable form which is more commonly a pathogen.[6] Virtually all the meningitic strains of the organism have been shown to be the B type, and rarely is the rough form pathogenic.[1, 7, 8] H. influenzae meningitis in the child usually follows a bacteremia, while in the adult meningitis more commonly comes from contiguous spread or is related to a coexistent defect in the skull. The fact that the patient had had a previous bacterial meningitis and had an infection with a nontypable form suggests either an anatomic defect in the skull or a defect in the immune mechanism.[8] A serum electrophoresis unfortunately was not done. The skull x-ray film was interpreted as normal. The malaise and upper respiratory symptoms of the week preceding the meningitis suggest a viral respiratory infection which is known at times to precede a bacterial infection.[9] The failure to demonstrate the organism on the initial Gram stain and the presence of an unusual pathogen, suggest that the common pediatric practice of initial multiple drug therapy for meningitis of unknown cause should be applied as well to adult practice.

** The organism was sent to the Communicable Disease Center, Atlanta, Ga., for further identification and typing. The report stated: "*Haemophilus influenzae*, rough, unable to type. Requires XV factors for growth. Serologically rough. No quellung in Haemophilus influenzae polyvalent serum."

Summary

A case is presented of meningitis in an adult caused by a nontypable Hemophilus influenzae. This was the second attack of meningitis in this patient which suggests the possibility of an anatomic or immunologic defect which would permit infection by a normal respiratory inhabitant. The etiology and pathogenesis have been discussed.

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PART II:

William Osler's Education

By JOHN H. GREIST, M.D., Madison, Wisconsin

OSLER LEFT Bovell and Toronto in 1870 and moved on to McGill where he was directed by Bovell because of greater clinical opportunities for his student, although the educational situation there was still far from perfect. Forty-five years later Osler remembered the Montreal General Hospital as an " 'old coccus—and rat ridden building, but with two valuable assets for the student—much acute disease and a group of keen teachers.' "[21] Here he emphasized the importance of associations with outstanding men, a habit he cultivated until, before long, he himself was outstanding and much sought-after as a clinician and teacher, writer and philosopher. However, the arrangements on the wards were not satisfactory, and Osler's experiences there sharpened his criticism and helped him shape standards for the later teaching services he directed. In describing the McGill experience he wrote,

> " 'The services were not separated, and a man for three months looked after medical and surgical patients, jumbled together in the same wards. The physic of the men who were really surgeons was better than the surgery of the men who were really physicians, which is the best that can be said of a very bad arrangement. We had to serve our time as dressers and clerks, and, indeed, in serious cases we very often at night took our share in nursing.' "[22]

As always with Osler, emphasis on the good features of the situation followed hard on the heels of just criticism.

> " 'There were four first-rate teachers of medicine on the staff—Howard, Wright, MacCallum and Drake—three of whom had learned at first hand the great language of Graves and Stokes. The bedside instruction was excellent. . . .' "[23]

This is the second part of an article which began in the April issue.

Cushing felt that:

> "Montreal in the '70's and for some years to come had unquestionably the best medical school in Canada, and the opportunities offered to students were possibly rivalled by those in only one city in the States,—namely, in Philadelphia. The McGill school, founded by Scotchmen, had from its inception closely followed the educational methods in vogue at Edinburgh, and . . . the students were given a degree of freedom in the wards such as existed in no other large hospital on the continent."[24]

Despite the pressures of his medical studies and clerking duties, he found time to continue his collection of Entozoa, to read widely from the volumes in Palmer Howard's library to which he had access, and to attend church regularly. Many of his useful habit patterns probably became fixed during this period. Those who knew him later were amazed at the breadth and depth of his knowledge of general literature. Cushing explains:

> "Probably it was at this early period that he began his life-long habit of a half-hour's reading in bed before putting out his light. Most medical students alas, are too engrossed with their work for such literary pursuits, desirable though they may be. But he never ceased to encourage the habit, and the books he recommended as a student's bedside library in all likelihood represent those with which he himself became acquainted in this way."[25]

As an appendage to his *Aequanimitas and Other Addresses*, Osler listed the Old and New Testament, Shakespeare, Montaigne, Plutarch's *Lives*, Marcus Aurelius, Epictetus, *Religio Medica*, *Don Quixote*, Emerson, and Oliver Wendell Holmes—as authors and works which would give one "the education, if not of a scholar, at least of a gentleman."[26] His love and knowledge of books was legendary and his generosity with books to others great. He would often buy three copies of choice volumes, one for himself, one for McGill's library and one for the Bodleian at Oxford where he was a curator and member by election to the Standing Committee for the last 15 years of his life. Further evidence of his scholarship in the classics is apparent in his writings and it was formally recognized when he was elected president of the Classical Association in London, in May of 1919. His first book purchase had been the Globe edition of Shakespeare's works which was later stolen.

His second purchase, in 1868, was the 1862 edition of Sir Thomas Browne's *Religio Medici*, the "very volume which lay on his coffin fifty-two years later."[27] In the interim between his first purchases and his death, his library grew to over 7,000 volumes, many of them the choicest incunabula of medicine and now permanently preserved and on display in toto in the Osler library at McGill.

But this has taken us away from McGill, where were sown many of the educational seeds that bore for so long such abundant fruit. Of Palmer Howard, Osler said,

> " 'In my early days I came under the influence of an ideal student-teacher, the late Palmer Howard of Montreal. . . . When I first, as a senior student, came into intimate contact with him in the summer of 1871, the problem of tuberculosis was under discussion, and . . . every lung lesion at the Montreal General Hospital had to be shown to him and I got my first-hand introduction to Laennec, to Graves and to Stokes, and became familiar with their works. No matter what the hour, and it usually was after 10 p.m., I was welcome with my bag, and if Wilks and Moxon, Virchow or Rokitanski gave us no help, there were the Transactions of the Pathological Society and the big Dictionnaire of Dechambre. An ideal teacher because a student, ever alert to the new problems, an indomitable energy enabled him in the midst of an exacting practice to maintain an ardent enthusiasm, still to keep bright the fires which he had lighted in his youth.' "[28]

OSLER SEEMS to have been describing himself as well. At graduation, his thesis was awarded a special prize for "originality and research," and as Osler later remembered, " 'I left the old General Hospital with a good deal of practical experience to my credit and with warm friends among the members of the staff.' "[29] These grew as the years passed.

In the summer of 1872, Osler set off for Europe for a period of postgraduate education as was the fashion and almost the necessity for serious students of his day. He worked for four months in John Burdon Sanderson's laboratory at a desk beside Charles Darwin's son. There, experimental physiology, histology, physiological chemistry and pathology were intertwined forming the warp and woof of structure and function which Osler grew to understand and later to teach so well. Thirty-four years later, he succeeded Sanderson as Regius Professor of Medicine at Oxford.

But Osler recognized that lectures and laboratories were not enough, and he spent the next months "walking the hospitals" with Murchison, Sir William Jenner, Ringer and others. He continued working in Sanderson's laboratory, and his study and description of platelets formed the basis of Sanderson's presentation of this discovery to the Royal Society. He was introduced to Lamb and Coleridge by his fellow student Arthur Browne, with whom he struggled to master the rudiments of German in preparation for his studies in Germany and Austria.

IN BERLIN, he was enthralled by the "mastermind" of Virchow at the Pathological Institute, and sent home to a Canadian Journal descriptions of the man and his educational system.

> " 'This most remarkable man is yet in his prime (52 years of age) and the small wiry, active figure looks good for another twenty years of hard work. . . . On Wednesday and Saturday the demonstrations take place in a large lecture-room accommodating about 140 students, and with the tables so arranged that microscopes can circulate continuously on a small tramway let into them. Generally the material from ten to twelve postmortems is demonstrated, the lecturer taking up any special group and enlarging on it with the aid of sketches on the blackboard, and microscopical specimens, while the organs are passed round on wooden platters for inspection. A well provided laboratory for physiological and pathological chemistry also exists as well as rooms where men may carry on private investigations; and a library and reading room is now being fitted up.' "[30]

After three months in Berlin, Osler journeyed to Vienna for five months of classes with Hebra in Dermatology and Rokitansky in Pathology, but found their instructions more descriptive and less stimulating than the experimental studies directed by Virchow in Berlin. Better, were operations by Billroth and best was midwifery. Osler wrote that he hoped to get three or four forceps cases before leaving. He felt " 'general medicine and pathology is infinitely below Berlin. After having seen Virchow it is absolutely painful to attend postmortems here, they are performed in so slovenly a manner and so little use is made of the materials.' "[31] These were mistakes he did not repeat when he was pathologist at the Montreal General Hospital, where in one year he personally conducted and reported 100 autopsies demon-

strating an industrious nature that was a trademark.

He returned to England from Vienna, finished the paper on platelets which Sanderson presented to the Royal Society after his departure, and, at a social function just before returning to Montreal, met Charles Darwin in what would seem a fitting close to his first European interlude.

In 1874, at the age of 25, he returned to Canada, his formal education completed. Throughout its course, he had striven to expose himself to the best that was available to him, in books, in laboratories, and especially in his associations with teachers, many of whom were, without doubt, among the best living at that time, both in Canada and Europe. He visualized travel as a part of one's education and felt it gave a broad perspective which, if approached with an open mind, proved a guard against provincialism and prejudice. And through it all, he worked hard at his studies as though following Lincoln's advice: Let us study and get ready and then perhaps the chance will come. It was not long before his chance did come.

AT FIRST he worked as a general practitioner and then took a month's locum tenens " 'for the consideration of $25 and a pair of old-fashioned elastic sided boots which had proved too small for Charlie O'-Reilly.' "[32] In July, 1874, he was appointed Professor of the Institute of Medicine at McGill and the next year the post of pathologist was created for him. He continued his pathological work for thirteen years and the dead house experience was always correlated with the patient's antemortem course. In 1878, after vigorous campaigning necessary in those days, he was appointed a full physician at the Montreal General Hospital. He spent the spring recesses of 1876 and 1877 in Boston familiarizing himself with the Harvard Medical School and attending the lectures of Bowditch on practical physiology, Reginald Fitz on pathology, and Oliver Wendell Holmes Sr. on anatomy. He started a journal club for the circulation of foreign journals and sent a regular report of the proceedings of the Montreal Medico-Chirurgical Society to the *Medical News of Philadelphia.* This communication served to introduce the quality and clarity of his thinking and exposition to members of the Philadelphia medical community, and undoubtedly played a part in the subsequent offer he received from the University of Pennsylvania to become Professor of Clinical Medicine. In the spring of 1878, he journeyed again to England for his "quinquennial braindusting" and to take the Royal College of Physicians examinations which he passed handily.

Most physicians are familiar with the outlines of the rest of Osler's career and accomplishments; the five years at McGill and Pennsylvania, the fifteen at Johns Hopkins and Oxford, the incomparable textbook, *Principles and Practice of Medicine,* the popular lectures and lay sermons, the writings on medical history, the work in public health, especially with respect to typhoid, his editorships, and many honors. In all, over 750 articles are published under his name, and as a measure of his generosity, 21 are found in first issues of new journals, many of which soon succumbed, although not without at least one article by the Regius Professor of Medicine at Oxford. It is patently impossible to review even in a cursory fashion, what Osler did and thought, although Cushing's biography of some 1400 pages and over 600 articles written about Osler since his death provide a measurement of the magnitude of his impact on those who knew him personally and even on those who came afterward.

In closing, a few of his thoughts on education may be recalled. For the medical student, his concern was that

> "the hardest conviction to get into the mind of the beginner is that the education upon which he is engaged is not a college course, not a medical course, but a life course, for which the work of a few years under teachers is but a preparation."[33]

Osler was concerned too for the licensed physician, for as he said:

> "If the license to practice means the completion of his education how sad it would be for the practitioner, how distressing for his patients! More clearly than any other the physician should illustrate the truth of Plato's saying that education is a life-long process. The training of the medical school gives a man his direction, points him the way and furnishes a chart, fairly incomplete, for the voyage, but nothing more."[34]

Osler's methods of pursuing a postgraduate education or any other worthy goal may be culled from his writings. In the previously mentioned lay sermon, "A Way of

Life," Osler preached from the "gospel of the day's work," and advised the habit of living in "day tight compartments." He was fond of quoting Carlyle: "Our main business is not to see what lies dimly at a distance, but to do what lies clearly at hand," and as a barb against procrastination, was known to chide others with MacBeth's lines, "The flighty purpose never is o'ertook unless the deed go with it." In an earlier address, "Teacher and Student," he recommended to his audience the Virtue of Method, the Quality of Thoroughness, and the Grace of Humility. In another relation, the "Master Word of Medicine," revealed in a 1903 address to the undergraduate medical students at Toronto and so obviously his personal fundament, was "Work."

OSLER recognized that the quality of habits determines, to a large degree, both the quantity and quality of an individual's productivity. He felt,

> "Post-graduate study is a habit of mind only to be acquired, as are other habits, in the slow repetition of the practice of looking at everything with an inquiring spirit. . . . There are many factors in this training, notetaking, reading, the medical society, and the quinquennial brain-dusting at a hospital or post-graduate school."[35]

Wilder Penfield, the famous Canadian neurosurgeon, met Osler as a Rhodes Scholar at Oxford. Later, during World War I, when he was wounded, he convalesced at Osler's home at 13 Norham Gardens, which was fondly known to many traveling Americans and Canadians as "Open Arms." At the time of the Centennial celebrating Osler's birth, Penfield wrote:

> "Sir William Osler devoted his mind to medical education, to the study of clinical problems and to the lore of medical history. . . . I would have you see him, as the least sentimental, the most helpful, most loveable teacher of medicine. He belongs to medical students of all time, as Lincoln belongs to common men everywhere, a man who grew to be what he was by dint of hard work, and in whose footsteps any undergraduate may dare to hope and dream that he may follow."[36]

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LIPOID PNEUMONIA

SCHWINDT, W. D., BARBEE, R. A. (University Hospitals, Madison, Wis.) and JONES, R. J.: *Arch. Surg.* 95:652–657 (Oct) 1967

Lipoid pneumonia should be kept in mind for patients who have an atypical pattern for tumor on chest x-ray films or in patients with a known exposure of ingestion of fatty compounds. Diagnosis was established in nine definite cases. The mean age of these nine patients was 52 years. Three patients were from a mental institution and one additional patient was debilitated with chronic lymphocytic leukemia. Four patients were asymptomatic; however, in the remaining patients, the symptoms ranged from mild chest pain and dyspnea to almost overwhelming pneumonia. In seven patients the diagnosis was obtained at thoracotomy. Postmortem examination established the diagnosis in one patient, and the other patient had a diagnosis made on a clinical picture compatible with lipoid pneumonia with positive sputum fat stains. Of the seven patients who underwent surgical procedures, six were operated on with a preoperative diagnosis of probably bronchogenic carcinoma. Since the first indication of possible lipoid pneumonia is from the chest x-ray film, particular attention should be directed toward some of the radiological features such as the early acinar pattern.

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Therapeutic Dilemmas

No. 7 of a Series

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These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

DESQUAMATIVE INTERSTITIAL PNEUMONIA

Moderator: GLENN H. FRANKE, MD

Participants: PATRICK ROE, MD
DOUGLAS D. KLINK, MD
ERNEST BURNELL, MD
GUENTHER POHLMANN, MD
ROBERT R. KOENIG, MD
GEORGE C. OWEN, MD

Dr. Glenn H. Franke: The title of our presentation this morning will have an unfamiliar ring to some of you because it is a new entity and our patient provides the first case of it that has been recognized at this hospital. The disease not only has very interesting diagnostic aspects, but it is peculiar, too, in that the remedial agents couple, with their very great effectiveness, the facts that they are unusually prone to cause excessive degrees of side-actions and to foment very severe exacerbations when they are considerably reduced in dosage. The subject is therefore altogether an intriguing one. Doctor Roe will present the protocol.

Dr. Patrick Roe (Resident in Medicine): The patient, a 27-year-old white man, was admitted to the hospital Dec. 7, 1967, with the chief complaint of persistent and progressive shortness of breath that began rather suddenly after a trip to Florida 2½ years before. The dyspnea was experienced not only upon exertion but sometimes at rest as well. There was a rather unproductive cough but no history of recurrent upper respiratory infections, wheezing, paroxysmal nocturnal dyspnea or orthopnea. In 1963 the patient had sustained several fractures in an automobile accident, and in 1964 had been exposed to tuberculosis at his place of employment. On admission he had been taking meprobamate, 400 mg q.i.d., and had taken other, unidentified tranquilizers since the age of 12. His mother is diabetic, and his father died of "cirrhosis" at the age of 47. A brother, aged 26 years, is said to be in good health, but an account of questionable clubbing has been elicited in this individual, who lives in another city. The patient smokes ¾ packs of cigarettes daily, is employed as supervisor for a steamship company, and his only known exposures have been to salted animal hides and to fumigants used in cleaning ships.

On admission physical examination the blood pressure was 145/92 mm Hg, pulse 92 and regular, heart rate and rhythm normal with no murmurs. The extremities showed clubbing of fingers and toes. There were fine, dry râles heard over both lung fields, laterally and anteriorly.

The white blood cell count was 13,100 per cu mm (1 band, 79 segmenters, 15 lymphocytes, 4 monocytes, 1 eosinophil); hemoglobin, 16.1 gm; erythrocytes, 5.68 million; hematocrit, 51%.

On Dec. 18 the patient underwent lung biopsy, and three days later the hemoglobin was 19 gm and hematocrit 58%; whether this increase was a response to hypoventilation postoperatively or a reflection of dehydration is unknown. Complement fixations were negative for histoplasmosis, blastomycosis, coccidioidomycosis, yeast phase antigen and mycelial phase antigen.

Dr. Franke: Thank you, Doctor Roe. Doctor Klink, do you care to make any remarks, since this is your patient?

Dr. Douglas D. Klink: I obtained a history of increasing shortness of breath during recent months, but what actually precipitated the examination of this young man was the fact that he was to be inducted into military service in four days and was not certain that he was physically fit. The subsequent course of events has proved him to be right in entertaining this doubt. He has now been placed on corticosteroids at the suggestion of Drs.

Figure 1

George Owen and Wilson Weisel, and symptomatically is much improved.

Dr. Franke: Doctor Burnell will present the x-ray findings.

Dr. Ernest Burnell (Resident in Radiology): The radiographic features of desquamative interstitial pneumonia (Fig 1) are those of the distribution primarily, which is basilar and posterior. There is a ground-glass appearance in the pulmonary bases. The first of the entities requiring differentiation from this malady would be the acute interstitial pneumonitides, but a helpful point regarding them is that they tend to disappear relatively rapidly. Then familial interstitial fibrosis of the Hamman–Rich type might present a problem; however, its distribution is universal rather than basilar. Another possibly confusing entity would be pulmonary hemosiderosis, not as seen in conjunction with mitral stenosis, but the idiopathic variety. Pulmonary alveolar proteinosis, too, has to be considered, but its distribution is usually perihilar rather than universal or basilar. Finally, there is the matter of eosinophilic granuloma or histiocytosis X, in which we customarily see a finely generalized reticulated pattern that usually requires biopsy to establish diagnosis.

Dr. Franke: Thank you, Doctor Burnell. Doctor Pohlmann will present the pulmonary function studies on our patient.

Dr. Guenther Pohlmann: We studied this patient when he entered in December, and unfortunately do not have the results of restudy as yet [but see Addendum—Ed.]. The important parameter to observe in the spirometry record (Fig 2) is that the fraction of the forced vital capacity expelled in the first second is 93% (the normal being 70%), which rules out obstructive airway disease and tends to place the patient's disorder in the category of restrictive ventilatory impairment. The lung volume determination (Fig 3) bears this out since restriction is observed in all compartments; the total lung capacity is down to 50%, and the helium mixing time of 45 seconds is short, meaning that the helium mixed rapidly so that there were no areas that were hypoventilated. The diffusing capacity (Fig 4) is also found decreased, but since the observed value of 11, compared to the predicted of 34, is less than would be expected solely from the patient's known restriction of alveolar space, we assume a true diffusion block in addition. The arterial oxygen saturation (Fig 5) was 89% at rest and dropped rather rapidly with exer-

SPIROMETRY

		Predicted Normal Value	Observed Value	% of Predicted
FVC	liters	5.46	2.43	45
$FEV_{1.0}$	liters		2.25	50
$\frac{FEV_{1.0}}{FVC} \times 100\%$		70	93	

Figure 2

LUNG VOLUME

Measurement		Predicted Normal	Observed Value	% of Predicted	Helium Mixing Time
VC,	L.	5.46	2.73	50	
FRC,	L.	2.85	1.84	65	
RV,	L.	1.56	0.73	46	45 sec.
TLC,	L.	6.90	3.46	50	
RV/TLC	%	34	21%		

Figure 3

PULMONARY DIFFUSING CAPACITY (D_{LCO})
12-7-67

Predicted D_{LCO}	34	ml./min./mmHg.
Observed D_{LCO}	11	ml./min./mmHg.

Figure 4

ARTERIAL BLOOD GAS STUDY

	Predicted Normal	Observed Values Resting	Exercise
SaO_2 %	95+	89%	80%

Figure 5

cise to 80%. When we saw the patient he had clubbing and peripheral, not central cyanosis, but with exercise he rapidly developed central cyanosis as well.

Dr. Franke: Thank you, Doctor Pohlmann. Doctor Koenig will show us some microscopic sections of tissue obtained in this case.

Dr. Robert R. Koenig (Department of Laboratories): Doctor Wilson Weisel (who unfortunately cannot be here this morning) supplied two excellent pieces of pulmonary tissue obtained by biopsy. The tissue was reddish-tan with areas of gray mottling, firmer than normal and non-crepitant. The histological appearance (Fig 6) is certainly not that of normal pulmonary parenchyma.

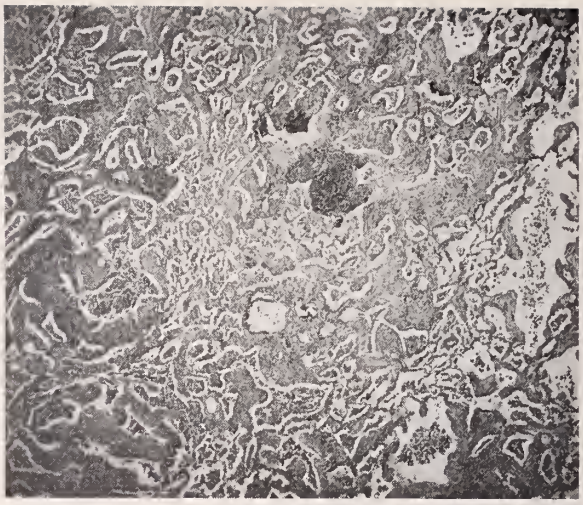

Figure 6

The majority of the alveolar septa are remarkably thickened, and there are a few clusters of chronic inflammatory cells irregularly distributed but mostly about the bronchioles. Notice particularly the absence of necrosis of hyaline membranes and of specific granulomata. The prominent feature on higher magnification (Fig 7) is the presence of numerous cells that are being desquamated in the alveolar spaces; they appear to be derived from the proliferating septal cells lining these spaces. A second hallmark of this condition, the first being the absence of specific necrosis, is the fact that these desquamating cells are very positive for PAS. One other condition in which one might find this PAS positive material would be alveolar proteinosis, but that is a diffuse granular deposition within the alveolar spaces and is not produced by accumulation of these pneumocytes, which appear to come *from* the alveolar septal walls.

A Physician: Where was your tissue from, and what was the rest of the lung like?

Dr. Koenig: It was from the lingula, and I can only surmise that the rest of the lung looked pretty normal since the x-ray picture shows this to be a basilar disease extending out to the lateral walls from the cardiophrenic angle.

Dr. Pohlmann: How can you say that this is a basilar disease really, since x-rays through the basilar area have to penetrate more lung tissue? The appearance on x-ray film may be a little deceiving?

Dr. Klink: Doctor Weisel felt, at least after the operation, that the lung was probably diffusely involved.

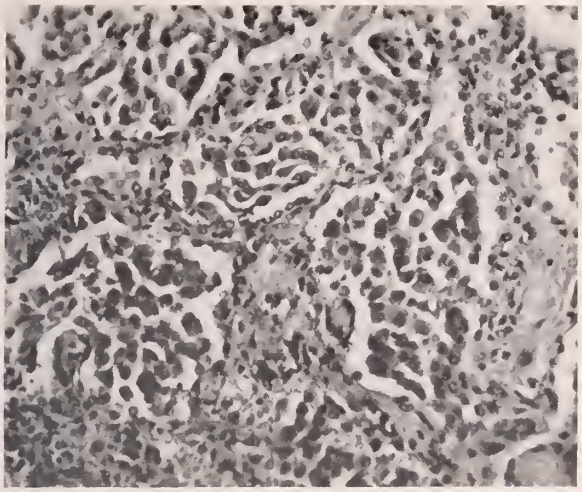

Figure 7

Dr. George C. Owen: Among the published cases there have been two instances in which biopsies taken from the areas shown to be involved in the x-ray picture and those apparently free in the upper lobes both revealed involvement. Diffuse involvement would certainly be more in keeping with the severe physiological defect in these cases.

Dr. Franke: Doctor Owen, would you care to discuss this entire subject more extensively?

Dr. Owen: This "new" entity was described by Liebow (A. A. Liebow, A. Steer and J. G. Billingsley: *Amer. J. Med.* 39:369, 1965) at Yale University in 1965, after studying sections sent to him from all over the country that seemed to fit into what he called the "monotonously uniform" pattern of no necrosis, no great tissue damage, and exfoliation of these peculiar large cells that he called granular pneumocytes. He described the findings in 18 cases, and when he was about to publish, Doctor E. A. Gaensler, of Boston, sent him material from another case for diagnosis. Then, having had his case identified as desquamative interstitial pneumonia by Doctor Liebow, Doctor Gaensler went into his files and found that 5 of 7 cases, discarded from a series of interstitial pneumonias some years before as being "atypical," conformed to Liebow's definition of this "new" entity (E. A. Gaensler, A. M. Goff and C. M. Prowse: *New Eng. J. Med.* 274:113, 1966).

Liebow's patients ranged in age from youth to advanced middle age, with equal sex distribution; and there was no environmental exposure to potential toxicants common to them. In the instances in which there was rapid onset and disablement there had been preceding respiratory infection of a usual sort. In some instances there were inclusion bodies, and perhaps serial sections of our material might reveal this also. Viral origin of the disease is not to be inferred from this, however, as there is as yet no inkling of the disease's etiology. There have been some observations indicating the possibility of producing the disease experimentally through intravenous injection of Freund's adjuvant in rabbits, thus raising the question of a hypersensitivity reaction of some sort underlying the entity. It is interesting that corticosteroids were able to prevent the occurrences in the rabbits (S. D. Deodhar and A. G. Bhagwat: *Arch. Path.* 84:54, 1967).

Doctor Klink's case could be called classical in that it occurs in a young individual, the onset is with dyspnea followed by cough, that the dyspnea increases, and that the x-ray film shows very little. I must enlarge upon this last statement by saying that the inevitable condensation of the roentgenogram in preparing a lantern slide yields the impression of much more than is really there; in the 14 x 17 chest x-ray film there is really very little to be seen. Actually, in 2 of Liebow's individuals the x-ray studies have been interpreted as normal. So far as pulmonary function studies are concerned, no uniform picture has been developed.

Isolated cases now being reported suggest that this malady may be a common one and also that it may run a very benign course (R. A. Klocke et al: *Ann. Int. Med.* 66:498, 1967). There are recorded instances of such extensive biopsy findings as have been presented here this morning in association with relatively little disability for as long as 12 years, and there have been clinical recoveries substantiated by disappearance of the preceding biopsy findings on repeat biopsy. Certainly this is a much more benign disease than the more familiar interstitial pneumonias, which so commonly go on slowly but inexorably to death. But I would nevertheless point out to you that the kind of tissue destruction that occurs in eosinophilic granuloma and in interstitial pneumonia, and ends in what we call the honeycombed lung, has been found to occur in this new desquamative interstitial pneumonia (DIP, in Liebow's designation): one of Gaensler's patients went on to death after 12 years and was found to have the honeycombed lung at necropsy.

In closing, I would stress, as a differential feature indeed, that these desquamative interstitial pneumonia patients often make an impressive and rapid response to corticosteroid therapy. They may show this response not only clinically but there is improvement in pulmonary function as demonstrated in the laboratory. But they have in common the feature, as mentioned by Doctor Franke in opening the discussion this morning, of almost invariably relapsing violently when attempt is made to reduce these drugs to maintenance dosage. Furthermore, many of the patients studied thus far seem exceptionally prone to develop the severe difficulties associated with use of these agents: cushingoid symptoms, diabetes, ulcer, and the like. However, one cannot as yet generalize about any feature of the disease since too few cases have been seen. Some patients *have* been able to stop the therapy and have gone on to apparent recovery.

The complications of the disease itself, not of the therapy, largely involve the pleura, as might be expected. Several instances are recorded of spontaneous pneumothorax, sometimes bilateral, and also of pleural effusion. When relentlessly progressive, the malady brings about more and more restriction, further loss of lung substance and decrease in lung size, the development of atelectasis and permanent contraction, usually in the lower parts of the lungs. Cor pulmonale has been rare.

Dr. Franke: Thank you, Doctor Owen. Are there questions?

A Physician: Doctor Klink, what dosage of corticosteroids do you have the patient taking now?

Dr. Klink: Presently he is receiving 40 mg of prednisone daily, and has shown symptomatic improvement. He is able to go upstairs and walk longer distances. I will be hesitant to decrease dosage rapidly because of the dangers already pointed out by Doctor Owen. Currently I am thinking of decreasing to 20 mg during a period of six weeks.

A Physician: Are other organs involved in the disease such as kidneys and the gastrointestinal tract?

Dr. Owen: The literature is still very limited. As I recall, there have been but two necropsies, and no findings were reported outside the lungs.

A Physician: Has the brother been studied? There was mention of possible clubbing in him.

Dr. Klink: The effort is being made. So far there has been no evidence of a familial element in the disease.

Dr. Owen: Interestingly, in several cases the clubbing in these people has regressed under the corticosteroids.

A Physician: What is the origin of the pneumocytes that have been stressed as characteristic of the disease? Are they lung cells or foreign to the lung? Perhaps I have missed a point in the discussion.

Dr. Owen: This is a pulmonary cell, but where it comes from, what its antecedents are, is not definitely established. However, its nuclear and cytoplasmic characteristics have been reported by Liebow to be similar to those of the typical large alveolar cells. He found them often to be in several layers, the more central cells closely resembling the free elements; this suggested a process of desquamation with gradual filling of the lumens of the alveoli. Liebow has tentatively identified these cells as granular pneumocytes rather than the membranous or phagocytic pneumocytes.

A Physician: Is there fever, and is the cough productive?

Dr. Owen: The patients are usually afebrile, but weight loss is common. The cough is not productive and the pneumocytes have not been recovered from the sputum.

Dr. Roe: May I call your attention to the first reported case in a child (R. M. Schneider et al: *New Eng. J. Med.* 277:1056, 1967), a four-year-old in whom studies of the hilar lymph nodes showed merely lymphoid hyperplasia. In this case also, attempt to discontinue corticosteroid therapy resulted in clinical and roentgenographic relapse.

Dr. Franke (summarizing): This has been a most interesting hour. It is not often that a case of a newly-described entity comes so quickly to attention in a relatively small community hospital. I am sure we are all most grateful to the participants this morning, who made us so aware of the features of desquamative interstitial pneumonia, alias DIP.

(ADDENDUM: The patient had repeat pulmonary function studies done on Jan. 23, 1968, six weeks after the initial study and approximately four weeks after initiation of corticosteroid treatment. He felt much better and stated that the dyspnea had decreased considerably. The findings, however, were essentially unchanged and reflected no objective improvement.—Ed.)

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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CURRENT TREATMENT OF HYPERTHYROIDISM

By NORMAN H. ENGBRING, M.D.
Milwaukee, Wisconsin

■ ALTHOUGH HYPERTHYROIDISM may have several causes, the most common types are associated with either multinodular goiter, sometimes referred to as Plummer's disease, or the diffuse goiter of Graves' disease. In Plummer's disease, hyperthyroidism is generally of mild or moderate severity, but occurs most commonly in elderly patients who have other disorders such as cardiac disease. In Graves' disease, hyperthyroidism is often more severe, but occurs most commonly in young or middle-aged patients. The means of therapy include: (1) *long-term antithyroid medication,* (2) *surgery,* or (3) *radioactive iodine.* Each has a proper role in current practice, but the choice of therapy must be individualized.

1. Antithyroid therapy is effective in controlling hyperthyroidism, but suffers several disadvantages. A successful course of therapy requires close cooperation with a strict regimen extending over one to two years, during which time the patient must be maintained in a euthyroid state. The major reason for failure is the lack of adherence to the regimen. Mild undesirable effects of the medication are not common, and serious reactions occur rarely. After a successful course of therapy, the relapse rate approaches 50%, necessitating another course or a more definitive form of therapy. The probability of prolonged remission is greater in children and young adults so that they are suitable candidates for antithyroid therapy. Propylthiouracil, 50 to 200 mg every 6 hours or methimazole (Tapazole), 5 to 15 mg every 6 hours, are most effective and least toxic. If the goiter is very large, the higher doses may be necessary. A single daily dose may be effective in milder cases but often fails. Methylthiouracil and carbimazole are more likely to produce undesirable effects. Iodothiouracil (Itrumil) has the distinct disadvantage of invalidating the PBI test, which is the best test to evaluate the effectiveness of therapy. In some patients undesirable effects of the medication may subside after changing to another antithyroid (i.e., from propylthiouracil to methimazole); however, at times another mode of therapy must be selected. Concern over bone marrow suppression must be tempered with the realization that granulocytopenia is a common manifestation of the hyperthyroidism of Graves' disease. If the patient develops an infection, a white blood cell count should be compared with the count obtained prior to therapy.

Clinical improvement is expected within two weeks after starting antithyroid therapy, and a euthyroid status within 4 to 8 weeks. A decrease in size of the goiter usually accompanies the clinical improvement and suggests a successful course of treatment. If the goiter is very large it may take longer to achieve a euthyroid state. Once the patient becomes euthyroid the addition of a full replacement dose of thyroid hormone (3 grains of desiccated thyroid daily), and a reduction of the dose of antithyroid should allow maintenance of a euthyroid state without the need for precise titration of the drug. At the conclusion of the course of therapy, the antithyroid medication should be discontinued and a radioiodine uptake test should be done while thyroid replacement continues. A high uptake presages relapse of hyperthyroidism, while suppression of uptake implies remission. Be-

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fore discontinuing thyroid hormone the dose should be gradually reduced over several weeks.

For the child or young adult who cannot readily be brought to or maintained in a euthyroid state with antithyroids, surgery may be preferable. This is more likely to be true when the goiter is large at the onset or enlarges after therapy has been initiated. Preparation of the patient in the hospital may be necessary prior to operation.

Hyperthyroidism during pregnancy is best managed with the antithyroid–thyroid combination. Reduction of the dose of antithyroid to the lowest effective level (100 to 150 mg of propylthiouracil daily) is recommended in the last trimester. Rarely, poor control of the hyperthyroidism may necessitate hospitalization for adequate control and subsequent thyroidectomy during the pregnancy. The physician must keep in mind that the normal PBI in pregnancy is in the range of 6 to 12 mcg per 100 ml serum in order to avoid over-treatment and the consequent goitrogenic effect on both mother and fetus.

The antithyroid agents mentioned above are thiocarbamide or thiourylene derivatives. They exert their effect primarily within the thyroid gland at the step of oxidation of iodide to iodine, which must precede the incorporation of iodine into the tyrosine or thyronine moieties of thyroglobulin. These antithyroid agents also have a peripheral effect in inhibiting the action of thyroid hormone. Perchlorate is an antithyroid which acts by inhibiting the trapping of iodide by the thyroid gland. This effect can be overcome by simultaneous administration of iodides. Perchlorate is no longer favored because of its frequent adverse effects. Iodides exert their antithyroid effect primarily by inhibition of hormone release from the gland and secondarily by effects on other phases of hormone synthesis. Iodides as definitive therapy of hyperthyroidism are not indicated since a euthyroid state can rarely be achieved or maintained. However, iodides still have a role in the treatment of thyroid storm and neonatal hyperthyroidism, and possibly in the preparation for thyroidectomy.

2. *Surgical thyroidectomy* is a definitive and effective means of therapy. It is the treatment of choice for the child or young adult after failure of a course of antithyroid therapy and for the adult who is still likely to have children. Surgical thyroidectomy also may be the preferred means of therapy for the patient with a rapidly growing thyroid nodule which suggests malignancy, when a large goiter causes compressive symptoms, when the patient expresses a morbid fear of radioactivity, and even for cosmetic reasons.

Prior to operation the patient should be restored to a euthyroid state with antithyroid medication so that surgery can be performed with no greater operative risks than for any elective procedure. Once a euthyroid state is achieved, iodides may be added to the antithyroid regimen for one or two weeks prior to surgery. If the patient has been euthyroid on the combined antithyroid–thyroid regimen, surgery may be performed without further preparation. Excessive medical therapy may lead to induction of hypothyroidism. This is accompanied by an increase in levels of thyrotropic hormone and a rapid increase in the size of the goiter due to increasing hyperplasia and vascularity. Surgery on such a friable gland is associated with excessive bleeding and is technically difficult. Restoration of a euthyroid state before operation, by addition of thyroid hormone for several weeks, will eliminate this risk.

The use of iodides as the sole preoperative medication may be sufficient in the patient with mild hyperthyroidism or may be necessary if the patient has reactions to the other antithyroid agents. As a rule, there will be incomplete control of the hyperthyroidism with a greater operative risk.

Disadvantages of surgical thyroidectomy include the minimal risk of anesthesia and surgery, hypoparathyroidism, and recurrent laryngeal nerve paralysis. Hypothyroidism occurs with a frequency not much lower than that after radioiodine therapy. In the hands of the occasional thyroid surgeon, all of these complications occur with greater frequency than when surgery is done by the expert.

3. *Radioactive iodine* is a definitive, effective and simple therapeutic agent for hyperthyroidism. Its use requires no hospitalization or interference with the patient's ordinary activities beyond the limitations imposed by the hyperthyroidism itself. With adequate dosage, the patient should be restored to a euthyroid state within 6 to 10

TABLE 1—*Treatment of Hyperthyroidism*

	Choice of Therapy		
	I-131	Surgery	Anti-thyroid
1. Children and young adults			+
2. Group 1—failure of antithyroid therapy		+	
3. Group 2—surgery contraindicated or refused	+		
4. Pregnancy			+
5. Pregnancy—failure of antithyroid therapy		+	
6. Beyond childbearing age	+		
7. Recurrent hyperthyroidism after thyroidectomy	+		

weeks. If inadequate, therapy may have to be repeated a second or third time. The major disadvantage to radioiodine therapy is the relatively high incidence of subsequent hypothyroidism, which may be expected in 20% to 50% of patients within 20 years after therapy. This incidence undoubtedly will increase as treated groups are observed for longer periods. Other disadvantages are largely theoretical and include the possibility of carcinogenesis which applies particularly to young patients, and genetic defects which may become apparent in future generations. The consistent demonstration of chromosomal abnormalities in white cells of radioiodine-treated patients warrants continued concern over these theoretical disadvantages.

When hyperthyroidism occurs after the childbearing age, radioiodine is the treatment of choice. This will include the large majority of patients. Relatively small (3 to 10 mc) doses are required for the diffuse toxic goiter of Graves' disease, and in these patients the incidence of hypothyroidism will be greater. Considerably larger doses (up to 30 mc) may be required for patients with toxic multinodular goiter (Plummer's disease), but the incidence of hypothyroidism in these is relatively low. Exacerbation of the hyperthyroidism has been reported to occur after radioiodine therapy in the very toxic patient; however, this must be very rare.

Radioiodine therapy is also preferred for recurrent or persistent hyperthyroidism after thyroidectomy, and may be the preferred therapy for young patients who cannot be managed with antithyroids and who have medical problems which make surgery a considerable risk.

Although the diffuse goiter will decrease markedly in size after radioiodine therapy, there is usually only slight or moderate decrease in size of the multinodular goiter. Malignancy in the multinodular goiter occurs with a frequency less than 0.1% so that surgical thyroidectomy based on fear of malignancy is not indicated unless additional factors, such as rapid growth of a nodule, make this probability more likely.

In the patient who tolerates hyperthyroidism poorly because of the severity of the disease or because of an associated disorder such as cardiac failure, it is advisable to reduce the hypermetabolic state as rapidly as possible. For this purpose, the sympathetic blocking agents such as reserpine or guanethidine, may be very helpful without affecting most thyroid function tests. These agents may be useful adjuncts to radioiodine or antithyroid therapy until thyroid function has been adequately reduced.

Thyroid storm, although rare, still presents a real medical emergency. This is a severe exacerbation of the hyperthyroid state usually precipitated by a stress such as infection. Antithyroids and iodides will impede the further synthesis and release of hormone from the gland, while reserpine or guanethidine will reduce the effect of previously released hormone. Intramuscular administration of reserpine, 0.5 to 2.0 mg every 4 to 6 hours often produces dramatic improvement within hours. Supportive measures should include intravenous fluids and electrolytes as well as hydrocortisone to avert the possible consequences of adrenal exhaustion. Attempts to reduce the fever with salicylates or by cooling are indicated. Treatment of cardiac failure, if present, and specific therapy of the precipitating factor must not be overlooked.

Regardless of the age of the patient or the method of treatment, periodic, life-long evaluation, primarily to detect hypothyroidism, is essential. Even in patients who have had no specific therapy, hypothyroidism may be the final phase of Graves' disease so that it is not necessarily the consequence of therapy. The tragedy of hypothyroidism is in missed diagnosis since the deficiency is so simply and effectively corrected. The physician who is alerted to this possibility will be much more likely to make the appropriate diagnosis than one who is not aware of the patient's previous history of hyperthyroidism.

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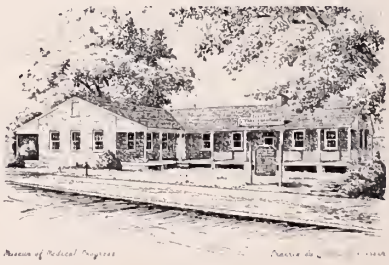

THE NEW PRESIDENT

WILLIAM D. JAMES, M.D.

A general practitioner with 26 years of service in the Oconomowoc community took office as the 110th president of the State Medical Society of Wisconsin at its 127th annual meeting May 11–16 in Milwaukee. He is Dr. William D. James who has distinguished himself not only in medicine but also in military service and civic affairs.

Born Oct. 17, 1906, in Evanston, Ill., Doctor James graduated from Lawrence College, Appleton, in 1927. He taught school for four years before entering the University of Wisconsin Medical School in Madison. In 1935 he received his degree in medicine and took internship and residency training at Milwaukee County Hospital from 1935 to 1937.

Doctor James started his practice in Oconomowoc in 1937 and in March 1941 was called to active military duty. After serving station hospitals in Oklahoma and Texas, he was transferred to the field troops and served as group surgeon for an Engineer Combat Group in the European Theater throughout World War II. He received the American and European Theater ribbons, the American Defense and Victory ribbons, Bronze Star Medal, and battle stars for the Northern France, Normandy, Rhineland, and Central European campaigns. He was discharged from active service in January

continued on next page

1946 after which he resumed his practice in Oconomowoc. He retired from the United States Army Reserve in 1966 with the rank of colonel.

Active in community affairs, Doctor James served several terms as city health officer, is a past president of the Kiwanis Club, and past commander of the American Legion Post No. 91. He is a member of the Masonic Lodge.

In activities of the State Medical Society, Doctor James served as an alternate delegate in 1953 and in 1954, when he was elected councilor from the first district. He held that office until his election as president-elect in 1967. As councilor he has served on various committees, most recently the finance and the executive committees.

Doctor James served as president of the Waukesha County Medical Society in 1948. He is a member of the American Medical Association and the American Academy of General Practice, and is on the medical staffs of Memorial Hospital, Oconomowoc, and St. Mary's Hospital, Watertown. In 1961 he was chief-of-staff of Memorial Hospital.

Doctor James is married to the former Ramona Enge and they have two children, Mrs. Peter (Sue) Prime of Oconomowoc, and Charles William, a student at Milton College.

SERVICES TO PHYSICIANS AND THE PUBLIC

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PUBLIC INFORMATION DEPARTMENT OF THE STATE MEDICAL SOCIETY

The following services are provided to member physicians and the general public, under the direction of the Commission on Public Relations and Communications—a standing committee of the Council. For the most part they are designed to assist the physician in preparing for participation in health education events such as speeches to non-medical audiences, or to provide factual health information directly to the general public. Address requests, or have your patients write: Public Information Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LOAN PACKETS

Packets of reference materials are provided, on a loan basis, on such topics as Fluoridation, Establishing a Practice, Health Fads and Fallacies, Alcoholism, Health Careers, Emotional Aspects of Malignancy, and numerous others.

FILM SERVICE

An index of films, suitable for both medical and non-medical audiences, is maintained by the Society. Please be as specific as possible concerning the desired topic. Since the Society does not maintain a film library and all films must be ordered from another source, two weeks notice is desirable. Cost normally involves only return postage, however in some cases there is a rental or service charge to be paid by the recipient.

HEALTH CAREERS MATERIALS

Materials on careers in medicine are available as references for physicians participating in Career Days and leaflets are available in quantity for distribution to groups. Reference materials on careers ancillary to medicine, and sources of loans and scholarships are also available.

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Single pamphlets are available on a wide range of topics for individuals seeking factual information on health.

MOUTH-TO-MOUTH BREATHING AND CLOSED CHEST CARDIAC MASSAGE

Films and a demonstration manikin are available for special programs on mouth-to-mouth breathing and closed chest cardiac massage. The latter topic is considered appropriate for physicians, nurses, policemen, firemen and rescue personnel, and requires supervision of a physician trained in the technique.

SPEAKERS SERVICE

While it is normally desirable to have a local physician fulfill speaking engagements in his community, speakers are available on the state level where a special topic or audience size makes it desirable.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

MAY 1968

Vol. 67 No. 5

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Perplexing Doctrine

■ A DISTRESSING TREND toward the increasing use of the doctrine of res ipsa loquitur in malpractice suits deserves the serious attention of both the medical and the legal professions. As a result of decisions applying the doctrine, the courts, in the last few years, seem to be saying that any unfortunate result occurring after a medical or surgical procedure is the responsibility of the physician even though the result was not necessarily related to the procedure involved.

Traditionally, the doctrine of res ipsa loquitur was invoked in a malpractice suit when it was obvious that an injury could not have occurred except through the negligence of the doctor. The application was generally limited to cases where an instrument or a foreign object was left in the body after an operation or where a part of the body not being treated was injured as a result of the physician's action. The new extension of the doctrine suggests that the physician be held liable for all possibilities no matter how remote. The application of res ipsa loquitur might now compel the physician to prove himself innocent of an accusation in spite of the fundamental principle of American law that a person is innocent until proven guilty. The increased use of the doctrine in recent years results from the apparent willingness of the judiciary, in some instances, to permit a physician to be held responsible for an untoward result rather than to deny a patient compensation for his injuries no matter how they were caused.

The possibility of a malpractice suit is a nightmare to most physicians. Often it comes totally unexpectedly and no matter how unfounded, it requires the physician to spend time, money, and effort in establishing a defense. Insurance carriers often attempt to settle out of court to avoid the cost of litigation, as well as the possibility that an errant jury may return a finding unwarranted by the evidence presented. In the meantime the damage to the physician's reputation caused by the publicity of the case is beyond estimate, as is the unnerving effect on the physician's self-confidence as a result of his being exposed to the trial-by-combat procedures of our legal system.

With the increasing use of the doctrine of res ipsa loquitur in malpractice suits in Wisconsin, the number of such cases has risen markedly. In these circumstances, could a physician do otherwise than become more cautious in his approach to his patient? Can a physician undertake a medical or surgical procedure with a patient without first considering all of the legal implications of his treatment? No physician with a decent respect for his own career and for the well-being of his family can now practice medicine without fear that, no matter how competent or careful he may be, his patient might make him the scapegoat for any unfortunate result, including the normal risks involved in therapeutic processes or even examinations. With such understandable inhibitions, some physicians are reluctant to take new patients or to treat familiar ones unless legally protective waivers are signed. In total, the increasing number of malpractice suits being filed must make the medical profession so wary that the best kind of medicine just can't be practiced, resulting in subtle erosion of the public health.

What can physicians do about it? Each of us must be wary, of course. We must be sure that a full and complete explanation of the risks involved in any treatment is given to the patient, preferably in the presence of witnesses.

On an organizational level, there should be interprofessional communication with the Bar in an effort to reduce the number of malpractice suits being filed without real cause for action. As physicians are subject to the censure of their colleagues for use of improper procedures, it is to be hoped that the Bar will exercise some kind of discipline over its members who file suits on frivolous or non-existent grounds.

Medical societies should also undertake the development of experts in forensic medicine who can advise the judiciary authoritatively or who can support the defense of a physician accused unjustly. Qualified professional testimony is often the only thing that saves a physician from a so-called commonsense judgment, and such testimony should be available to him when he is being victimized—as well as to his patient who has suffered bona fide, actionable damage. If the present trend in the number of malpractice suits continues, the inter-relation between law and medicine must become a field of major activity.

It is unfortunate that physicians can no longer practice medicine as best they can without looking behind them for the legal bogeyman. Surely the appellate courts which have set aside the decisions of trial courts in order to apply the doctrine of res ipsa loquitur must realize what a box of evil their landmark decisions have opened. But until all courts recognize that their proper business is justice, and not charity at the expense of physicians and insurance carriers, physicians must take every measure to protect themselves against the avarice of those who see them as sitting ducks for a quick buck.

—D.N.G.

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LETTERS

ORGANIZED MEDICINE DEFENDED

To. MR. CROWNHART:

Congratulations on "The Medical Student Forum" whereby your Wisconsin State Medical Journal affords an opportunity for free expression of opinion on the part of the students attending the University of Wisconsin and Marquette Medical Schools.

As a Marquette graduate of thirty years ago, may I comment on your March issue and the Forum opinions expressed by a medical student.

He writes:

"Idealistically, we students think that the welfare of the patient should be the primary consideration, . . ."

In thirty years of practice and in travels affording me the opportunity to view my fellow physicians working in all fifty of our states, I can report without equivocation that this is and has been the primary consideration of untold thousands of the members of our profession. It is uncommon to find even a rare exception whose views and practices contravert this basic idealism which still motivates most physicians.

Your writer continues:

"We have not forgotten the ugly scenes we have witnessed where medical care was not given or was severely delayed because it was feared that the patient might not be able to pay."

Perhaps I have been fortunate but not once in thirty years have I been exposed to nor seen evidence of such "ugly scenes" resulting from the personal refusal of a physician to render needed service.

And, finally, your writer stated:

"We students think that the leadership of the medical profession should be using its intelligence and position to explore new approaches to some of our country's health problems, instead of using the wealth and prestige of the profession to stifle new ideas. Many students were quite ashamed of the massive effort of organized medicine to kill the Medicare bill without offering practical solutions to the obvious problem."

It is obvious that the writer is unaware of the continuous efforts of medical researchers, medical teachers and medical clinicians to whom he should be grateful for the quality of today's medicine and for the rapidity with which it adapts to progress and change.

I know of no effort, miniscule or massive, on the part of organized medicine to kill the Medicare bill without offering practical solutions to obvious problems. Medicare has proven already that our prognostications were correct as to its spiraling costs, its bureaucracy, its red tape and the ever-increasing encroachment of its restrictions. The position of medicine has been consistent in the belief that those in need of help should have it, but that the government's role should be limited to providing aid and assistance to those of our citizens who need help.

What medical student would justify giving medical treatment to all members of a family when only some of them are sick? How then can we justify increasingly taxing workers to cover everyone over age 65 including the rich who do not suffer from economic illness.

Medicare is a prime example of a hastily conceived and poorly designed program which was politically enacted by arm twisting and coercion. Medicare can be viewed as "good legislation" only by the uninformed or by those who believe that "might makes right."

Today, Medicare is law. Our responsibility as physicians and as citizens is to do everything we can to reach its desired objectives, namely, better care for all senior citizens. To deny its shortcomings or to fail in our efforts to prevent its further expansion in present form would, in my opinion, be a disservice to truth and detrimental to the best interests of the patients we serve.

EDWARD R. ANNIS, M.D.
Past President, AMA

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

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SPECIAL TO THE JOURNAL

High Quality Drugs at Reduced Cost for Hospital Patients

By JAMES GUENTHER, R.Ph., SISTER M. PIO, Chief R.Ph.
and FRANCIS N. LOHRENZ, M.D., Marshfield, Wisconsin

■ MUCH HAS BEEN written about drugs which physicians prescribe by brand name.[1,2] This issue has become prominent because:

(1) The cost of drugs paid by Medicare or Medicaid is under consideration.

(2) A Congressional Committee, chaired by Senator Gaylord Nelson of Wisconsin, has caused recurrent evaluation of drug prices.

A simple way to deliver drugs at reduced cost to patients in the St. Joseph's Hospital, Marshfield, Wisconsin, has been in effect for the past four months. This program was established by the following method. The Hospital Services Committee, in cooperation with the pharmacy, chose three frequently used drugs. Permission was given by the medical staff for the pharmacy to give equivalent doses, regardless of whether the drug was ordered by generic or brand name. Estimates of the number of units needed for each item were made. The pharmacy then purchased the drugs at large-quantity discounts. These discounts were significant enough that bids from major reliable pharmaceutical firms made possible a reduced price to the patient.

From St. Joseph's Hospital, the Marshfield Clinic, and the Marshfield Clinic Foundation for Medical Research and Education, Marshfield, Wis. 54449.

Mr. Guenther and Sister M. Pio are from the Pharmacy, St. Joseph's Hospital, Marshfield; and Doctor Lohrenz is from the Department of Internal Medicine, Marshfield Clinic.

Table 1 shows the drugs used with the price per unit to the patient before and after the institution of this plan.

Table 2 shows the savings transmitted to the patient during the four months this plan has been in effect.

It can be readily seen that the saving to the patient has been considerable in three different frequently used antibiotics. Several other drugs are being subjected to the same bidding-process technique at this time.

It must be emphasized that this program required: (1) Coopera-

continued on next page

TABLE 1

Drug	Before	After
Ampicillin Capsules		
250 mg	$ .45	$ .25
500 mg	.80	.50
Ampicillin for Suspension (Bottles)		
125 mg/5 ml	4.60	3.00
250 mg/5 ml	8.80	5.50
Ampicillin for Injection		
125 mg	3.75	3.50
250 mg	4.00	3.75
500 mg	4.50	4.00
1000 mg	5.00	4.50
2000 mg	9.00	7.75
Penicillin-V Potassium		
250 mg	.25	.20
Tetracycline Capsules		
250 mg	.20	.15
Tetracycline for Injection		
100 mg IM	3.00	2.25
250 mg IM	3.75	2.75
500 mg IV	4.50	3.00
Tetracycline Suspension		
125 mg/ml (60 ml)	2.80	1.25

Period covered: Oct. 16, 1967, to Jan. 29, 1968.

BOOKLET: "TREATING CANCER"

Current methods of treating cancer by surgery, radiotherapy, and chemotherapy are described in a 20-page booklet, "Treating Cancer," issued for the general public by the Public Health Service, U. S. Department of Health, Education, and Welfare, and prepared by the National Cancer Institute, National Institutes of Health.

The booklet discusses new operating room techniques that facilitate a surgical patient's rapid recovery, and describes recent advances in patient care and rehabilitation. Various approaches to radiotherapy, including conventional x-ray, supervoltage irradiation and radioactive isotopes are reviewed.

Single copies of "Treating Cancer" (PHS Publication No. 690) are available without charge from the Public Health Service, Washington, D. C. 20201. The booklet may be bought in quantity from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402 at 20 cents a copy.

tion on the part of the medical staff. (2) Delegation of authority to the pharmacy to decide which drug companies were reliable. (3) Faith in the hospital pharmacy and administration that savings achieved by bid techniques would be transmitted to the patient.

SUMMARY

A method of delivering high quality hospital drugs at reduced cost to patients, which circumvents the necessity for the use of generic names and which does not require new legislation or new hospital committees, has been in effect at the St. Joseph's Hospital, Marshfield, Wisconsin, for the last four months. This project produced no inconvenience to the physician, patient, hospital administration, or pharmacy, and is suggested for use in other hospital situations and privately owned pharmacies.

REFERENCES

1. Burack, Richard: *The Handbook of Prescription Drugs*, New York: Pantheon Books, a division of Random House, Inc., 1967.
2. *The Medical Letter on Drugs and Therapeutics*, Vol. 9, No. 11 (Issue 219), published by Drug and Therapeutic Information, Inc., New York, June 2, 1967, pp. 41–44.

TABLE 2

Drug	Number of Doses	Savings to Patient
Ampicillin Capsules		
250 mg	1,500	$ 225.00
500 mg	1,720	725.00
Ampicillin for Suspension		
125 mg/5 ml (80 ml)	12	21.60
250 mg/5 ml (80 ml)	53	174.90
Ampicillin for Injection		
125 mg	112	27.50
250 mg	116	33.00
500 mg	859	429.50
1000 mg	1,359	679.00
2000 mg	170	196.35
Penicillin-V Potassium (tablet)		
250 mg	460	23.00
Tetracycline Capsules		
250 mg	4,880	244.00
Tetracycline for Injection		
100 mg IM	12	9.00
250 mg IM	52	45.00
500 mg IV	12	3.00
Tetracycline Suspension		
125 mg/ml (60 ml)	15	10.50
Total	11,332	$2846.35

Period covered: Oct. 16, 1967, to Jan. 29, 1968.

AAGP ANNOUNCES NEW PRACTICE MANAGEMENT GUIDE

A 105-page manual designed to provide the general or family physician with professional help in handling the complicated business aspects of medical practice and the important community and professional relationships involved has been developed by the American Academy of General Practice.

The manual "Organization and Management of Family Practice" attempts to fill an urgent need for expert advice in an area largely neglected by medical schools and professional organizations, states Dr. Raymond M. Kahn, chairman of the AAGP Committee on Medical Economics which guided development of the manual. It is aimed at the graduate who wishes to avoid costly errors in establishing his first practice, and the practicing physician who wants to evaluate the efficiency of his present office procedures, Doctor Kahn says.

The illustrated handbook contains three major sections, including an introductory description of the content of family practice and the functions of the family doctor; a major middle section dealing with the business of running an office practice, and a third part describing the community resources and professional associations available to the practicing physician.

A 50-page middle section provides guidance to the new physician on such vital decisions as what type of private practice to enter; what region, state and type of community will best satisfy his personal, professional and economic requirements for a practice location; how to select the ideal office layout, decorate attractively and functionally, and select expensive office, diagnostic and laboratory equipment.

In the area of office management, the manual offers detailed professional guidance as well as practical tips from experienced practitioners in selecting, training and keeping an effective office assstant; efficient record-keeping of patient clinical and financial histories and office accounting; establishing an efficient office appointment system, fee schedule and credit, collection and third party billing procedures.

Copyrighted models of the patient record forms, billing statements and office business forms discussed are reprinted actual size at the end of the section.

The manual is being made available to all Academy members. It also will be made available free of charge on request to medical students, interns, residents and medical school and hospital libraries. Others interested in obtaining a copy may do so at $1 per copy from the American Academy of General Practice, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

ON JANUARY 5, 1968, Governor Warren P. Knowles released the report of his Task Force on Medical Education, a committee which he had appointed on March 6, 1967, to study and examine all available materials in the form of special papers and studies prepared by the staff and the two Wisconsin medical school deans in laying the groundwork for major steps forward in providing improved health care to the citizens of Wisconsin. Because the report has such far-reaching interest to medicine, its summary of findings and recommendations is printed below. The full report may be obtained by request to: Department of Administration, Bureau of State Planning, 1 West Wilson Street, Madison, Wisconsin 53702.

TASK FORCE ON MEDICAL EDUCATION

Summary of Findings and Recommendations

FINDINGS

Wisconsin's need for physicians:

• Wisconsin's level of resources for health care—in terms of physician manpower—is below the averages for both the Midwest and the entire nation. Nationwide there are 143 physicians per 100,000 population; the seven upper Midwest states have an overall ratio of 136; Wisconsin's ratio is 119.

• Wisconsin has experienced a net annual out-migration of 19 newly-trained physicians over the past 11 years. During this period, the two medical schools in this state produced an average of 161 physicians per year (Marquette School of Medicine—55%; University of Wisconsin—45%). However, the state has averaged an increase of only 142 new physicians per year.

• Recent data show that the drop-out rates of students who enter the two medical schools in this state are higher than the national average. In recent years, the rates for the University of Wisconsin Medical School and the Marquette School of Medicine have averaged 14.5% and 11.2% respectively. The national average during that period was 9.7%.

• Post-graduate educational opportunities in this state are less than in the nation generally. Wisconsin has about 2% of the national population and enrolls 2.1% of total undergraduate medical students. Yet, Wisconsin hospitals offer only 1.6% of the nation's total internships and only 1.7% of resident positions. Further, the overall record of these hospitals in filling these post-graduate positions is under that of the nation generally, although the record of medical school affiliated hospitals is good. Because the existence of quality post-graduate educational opportunities is an important factor in the decisions of doctors to practice in a given location, the present inadequacies seem to contribute to Wisconsin's net annual loss of newly-trained physicians.

• To provide a level of physician manpower close to the anticipated national average by 1985, and the Task Force believes Wisconsin citizens desire and deserve this level of health care, this state must expand its programs for training new physicians from 211 first year places now to 420 first year places by 1975–77. At the same time, it must strengthen the quality of present teaching programs to reduce the attrition rate for undergraduate medical students and expand and strengthen the post-graduate education programs to at least balance the number of migrating physicians.

Location of medical school expansions:

• Based on the existing concentrations of population and the forecasted heavy population gains over the next two or three decades in these areas, and the existing and planned clinical facilities and other basic science capabilities, the most logical distribution of entering medical students would be: 160 at the University of Wisconsin Medical School, 160 at the Marquette School of Medicine, and 100 at a new medical school to be established at the University of Wisconsin–Milwaukee.

• The University of Wisconsin Medical Center at Madison and the Milwaukee County Medical Center and Marquette School of Medicine make these institutions logical for the further development and expansion into strengthened nationally-recognized centers of education and health care.

• The development of a new medical school at the University of Wisconsin–Milwaukee offers an especially challenging opportunity—an opportunity to incorporate the best elements of present medical education with new ideas and concepts for training physicians for delivering medical care services.

The future of the University of Wisconsin Medical School and the Marquette School of Medicine:

• The physical plant and site of the University of Wisconsin Medical Center are inadequate for the proposed expansion from 104 to 160 entering medical student places. This clearly points in the direction that the University has concluded is necessary

—to program and construct new medical school facilities at the west side campus site adjoining the Veterans' Administration Hospital.

• The University of Wisconsin Medical School's heavy dependence on extramural funding makes the teaching, research and service programs of the school vulnerable to variations in financial support from outside sources. A higher level of state support would help reduce the attrition rate.

• In September 1967, the Marquette University Medical School Corporation was reorganized. By this action, the medical school severed all legal ties with Marquette University, and the name was changed to Marquette School of Medicine, Inc.

• The basic science facility of the Marquette School of Medicine is obsolescent and inadequate. The school has plans to replace this facility at a cost of $22.7 million, to be paid from private and federal sources.

• The Marquette School of Medicine faces critical financial problems for its operating programs and in the continued operation of the school. The school is currently operating at a substantial deficit. This is due to the fact that medical education costs have risen faster than existing sources of revenue. To meet this problem, the Milwaukee Medical Center Steering Committee and MSM have jointly requested that $1.3 million in state funds be appropriated to Milwaukee County in each year of the current biennium to cover anticipated deficits.

• A higher level of state support than that needed to cover the deficit would help reduce the attrition rate at MSM.

Other health professions studies:

• Extensive statistical data developed by several professional groups as well as the Coordinating Committee for Higher Education, together with the daily experience of doctors and patients throughout the state, clearly demonstrate that critical shortages exist in nurses and all other categories of paramedical personnel. As a result of our discussions about the expansion of physician training programs, it is urged that this be accompanied by a proportionate statewide expansion of training programs for paramedical personnel. In addition, other studies are underway relating to paramedical personnel. For example, the Coordinating Committee for Higher Education is studying statewide programs of nursing education.

RECOMMENDATIONS

Based on our studies and these findings, the Task Force recommends that:

1. The incoming freshman class at the University of Wisconsin Medical School be increased from 104 to 160 places as soon as feasible. To accomplish this, immediate action should be taken to develop the master plan for the medical center to provide the facilities and site necessary to replace and expand the existing physical plant. This planning should take into account the need for time phasing of the physical facilities replacement and expansion so as to provide for orderly growth of the educational program and spacing of the capital expenditures. At the same time, adequate financial support should be provided and other appropriate actions taken to reduce present medical school attrition rate to no more than the national average.

2. Action be taken to assure the continued existence of the educational programs of the Marquette School of Medicine. The Task Force recommends that the Marquette School of Medicine be expanded to 160 first year places as soon as feasible. We recognize that state financial support will be needed to accomplish that objective and to strengthen teaching programs and reduce the attrition rate of medical students. The Task Force did not address itself to the public policy question of providing public funds to a private educational institution. This is a matter which must be considered and resolved by the Legislature.

MEDICAL EDUCATION TASK FORCE

Donald C. Slichter ------Chairman, Milwaukee
William Kraus ----Vice Chairman, Stevens Point
Norman Anderson --State Assemblyman, Madison
Thomas Barland ------County Judge, Eau Claire
Norman Becker, M.D. ----------Fond du Lac
John W. Cowee
------Provost, Marquette University, Milwaukee
Mrs. Richard Cutler ----------Milwaukee
T. A. Duckworth ----------Wausau
Peter Eichman, M.D.
--Dean, Medical School, University of Wisconsin
Orval Guenther ----------Milwaukee
William C. Hansen -State Senator, Stevens Point
Walter G. Hollander --State Senator, Rosendale
Gerald Kerrigan, M.D.
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Russell Lewis, M.D. ----------Marshfield
David Martin -------State Assemblyman, Neenah
Bertram McNamara ----------Milwaukee
Donald F. Taylor ----------Merrill
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TASK FORCE STAFF

Harry K. Spindler—Staff Chairman; Assistant Director, Coordinating Committee for Higher Education

Robert D. Coye, M.D.—Associate Dean, Medical School, University of Wisconsin

Symond R. Gottlieb—Executive Director, Hospital Area Planning Council

Walter McCanna—Assistant to the Academic Vice President, Marquette University

Roger Schrantz—Director, Policy Planning Division, Bureau of State Planning, State Department of Administration

Warren Exo—Education Planning Analyst, Department of Administration

3. Authorization be provided by the Legislature and planning funds allotted so that the University of Wisconsin can proceed to develop a new medical school in Milwaukee as expeditiously as possible. As much as ten years lead-time is required from the time of authorization for a new medical school to the time students are actually graduated. Planning should proceed for the enrollment of first year students in the 1971–73 biennium and expansion to 100 first year students during the 1975–77 biennium.

4. The state strengthen, as soon as feasible, its post-graduate medical education training programs, and that as a beginning the legislature appropriate funds for the development and implementation of pilot programs of post-graduate medical education to be undertaken by the medical schools of the state in cooperation with other appropriate agencies and organizations in various areas of the state.

COSTS OF THE RECOMMENDATIONS

These costs are projected in terms of 1967 dollars and salaries and assume current tuition levels:

1. The facilities cost for replacement, improvement and expansion of the University of Wisconsin Medical School, including the expansion from 104 to 160 entering medical student places, is estimated to be $64 million, spread over four or five bienniums. Of this amount, about $30 million would be the State's share, or an average cost of $6 to $7.5 million per biennium.

Based on the proposed expansion programs, the medical school's operating budget will increase from $13 million in fiscal year 1967, of which the State's share is $3.8 million, to a total operating budget of $17 million in fiscal year 1975, of which the State's share will grow to $5.8 million.

2. The facilities cost of the total program of expansion proposes for the Southeastern Wisconsin Medical Center, which includes the Marquette Medical School expansion of entering undergraduate medical places from the current 107 to 160 places, is estimated to be approximately $92 million. These expenditures would be financed from the county, federal and private sources and would be spread over a period of 10 years.

Based on the recommended program, the total operating budget for the Marquette School of Medicine will increase from $7.8 million in fiscal 1968 to $9.8 million by 1975. The projected operating deficit for 1968 is approximately $1.3 million. State funding of this deficit plus an additional $1.1 million of State funds for the improvement of quality and the expansion of enrollment would result in a total state share of $2.4 million annually by 1973. It would cost an additional $205,000 annually in state funds if the school's tuition charges for Wisconsin residents were set at the same level as those currently in effect for the University of Wisconsin Medical School.

3. Complete figures on the cost of facilities for the proposed University of Wisconsin–Milwaukee School of Medicine are not available. The minimum cost of a basic science building was projected by the University of Wisconsin to be approximately $10 million of which about $5 million would be the State's share.

The initial operating budget for teaching and administration costs of the University of Wisconsin–Milwaukee is envisioned by UW officials to be approximately $4 million annually, with about $2.6 million annually as the State's cost.

The figures given for the facilities costs and operating budget expenditures for the University of Wisconsin–Milwaukee School of Medicine are only preliminary estimates. The development of detailed cost data must be based upon a comprehensive plan. An estimated $100,000 would be required for the UW–M to start promptly on this plan. Until a plan is developed, these preliminary estimates provide only a rough guideline.

4. The cost of funding pilot program efforts to improve post-graduate medical education in outstate hospitals is projected at $100,000.

BROCHURE: NURSING EDUCATIONAL OPPORTUNITY GRANTS—INFORMATION FOR SCHOOLS

A new financial assistance provision to encourage needy, capable high school students to become professional nurses is now part of the Nurse Training Act.

The Division of Nursing, U. S. Public Health Service, which is responsible for the aid programs authorized by this Act, has issued a brochure, "Nursing Educational Opportunity Grants—Information for Schools," describing the new program.

As stated in the Nursing Educational Opportunity Grants brochure, scholarships of up to $800 a year are available for qualified high school graduates of exceptional financial need who are admitted to nursing education programs and make satisfactory progress.

All types of public and nonprofit private nursing education programs—diploma, associate degree, and baccalaureate degree—are eligible to receive Nursing Educational Opportunity Grants for disbursement to students if they meet certain requirements as described in the brochure.

For information about the five other programs authorized by the Nurse Training Act to aid students and schools of nursing, write to the Division of Nursing, U. S. Public Health Service. Brochures concerning each of these programs, and the new brochure, "Nursing Educational Opportunity Grants—Information for Schools," are also available from the Division, 800 North Quincy Street, Arlington, Va. 22203.

THE MEDICAL STUDENT FORUM

Devoted to the expressions of the medical students at the University of Wisconsin and Marquette medical schools through association with the Student American Medical Association. A feature originated by the State Medical Society of Wisconsin to stimulate closer relationships with the physicians of tomorrow. This space is offered monthly to both schools on an alternating basis, with copy deadline the first of the month preceding the month of publication. Statements and opinions contained herein are those of the students.

MAY 1968

TODAY'S MEDICAL STUDENT is taking advantage of unprecedented opportunities to become a citizen of the world. Though not much richer than he used to be (the average debt per graduating doctor is $4000–$5000, with the average in-debt student owing around $8000), he is being freed from the worry of making ends meet. The increasing availability of loan money and blonde scholarships (working wives) is freeing the student from the menial, unrelated floor-scrubbing and dish-washing of old. He has not become lazy: medicine-related jobs with potential learning value and pay commensurate with education are quickly snapped up. But the new freedom from economic necessity gives the student the luxury of time, and the choice of how to use it.

FINANCIAL WORRIES ARE LESS

Educationally, too, there is a broadening of horizons. In the early 20th century, medical training consisted of a two-year clerkship. Then for fifty years it was a four-year study divided between basic sciences and clerkship. Today, sciences other than the biologic are having a great impact on medicine. Med students are participating in the University milieu and interacting with their neighbors; they're studying sociology, ethics, politics, and psychology to get an understanding of these influences on health, not only in America, but elsewhere in the world. Medical education is evolving into an integrated study of people—in health and disease, as social, moral, political, psychologic, and biologic entities.

With the increased freedom and awareness comes a new sophistication. Today's student is finding the opportunity to overcome the mechanical and grapple with the philosophical. Instead of being amazed by new drugs or cardiac intensive care units he is amazed that certain social and economic groups in this country lack even minimal health standards. In a broad but very real sense, students are becoming concerned not with what medical science has achieved, but with what it can and should achieve in the near future.

CONCERN FOR THE FUTURE

These trends are translating themselves into actions, movements of students to set up prototypic and functional health care facilities. We at Wisconsin are becoming particularly concerned about the needs of the American Indians, the hard-core area residents of Milwaukee and other large cities, and the migrant workers; Wisconsin volunteers worked with the latter group in a pilot program last summer, and found the experience most interesting.

The medical student of today is reflecting some of the changes of society in general and preparing to become motive power rather than mirror.—RICHARD CHRISTENSON, President, SAMA, University of Wisconsin, Madison.

BOOKLET: DRUG ABUSE PROBLEM

Widespread concern, particularly among alarmed parents, over the nation's rising drug abuse problem and the raging "front-page" controversy centered around the increasing use of LSD, marihuana and other hallucinogenic drugs by thrill, curiosity and "self-improvement" seekers on and off college campuses has spurred the AMA to develop a 25-page booklet, "The Crutch That Cripples: Drug Dependence."

The publication is designed to give the public a sound understanding of drugs, their uses and abuses and the problems which irresponsible use leaves in its wake.

The publication was prepared by the Committee on Alcoholism and Drug Dependence, Council on Mental Health, in response to heavy mail and telephone inquiries received in recent months by the AMA's Department of Mental Health.

Written lucidly and in colorful language readily understood either by parents or the younger set, *The Crutch That Cripples*, discusses all aspects of drug use.

Among the topics covered are medical uses of drugs, drug dependence, drug abusers, abuse of narcotics, sedatives, stimulants and hallucinogens, where to get help for drug abusers and prevention of abuse. The booklet also calls attention to a current bibliography available from the Department of Mental Health on drug abuse and drug dependence.

Copies of the publication may be obtained from the AMA Order Department. Single copies are 25 cents. Reduced prices, ranging downward to 17 cents each for lots of 1,000 or more, are offered on quantity orders.

THE THIRD REVISION of *Group Practice: Guidelines to Forming or Joining a Medical Group*, originally published in 1962, is now off the presses. Medical societies and individual physicians may obtain complimentary copies by writing the Department of Health Care Services, American Medical Association.

Jointly produced by the AMA, the American Association of Medical Clinics and the Medical Group Management Association, the 40-page booklet covers all aspects of group practice.

SECTION OPHTHALMOLOGY

MAY 1968 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN SOCIETY FOR THE PREVENTION OF BLINDNESS—A HELPFUL ORGANIZATION

The Wisconsin Society for the Prevention of Blindness, Inc. is a public service organization dedicated to the prevention of blindness in the state of Wisconsin. It is an affiliate of the National Society for the Prevention of Blindness, Inc. This parent organization was founded in 1908 and is the oldest voluntary health agency nationally engaged in prevention of blindness through a comprehensive program of community services, public and professional education, and research. As a state affiliate, the Wisconsin Society adheres to the programs, community services, and standards of the National Society but operates as an independent entity to serve the needs of the state.

Relatively speaking, the Wisconsin Society is a youngster, having been organized some 10 years ago and incorporated in 1965. But since its limited beginnings, demands for the Society's programs and services have grown steadily, reaching adult proportions today and expanding out of the Milwaukee area to encompass the entire state.

Its programs are many and varied ranging from preschool vision screening, glaucoma screening, eye safety in industry, schools and vocational areas to a broad program of lay and professional education on eye health and eye care. Publications, posters, films, lectures, and advisory service are available free upon request.

One of the growing programs for which the Society receives requests for leadership, guidance, and training is preschool vision screening. Requests come not only from lay service organizations, eager to sponsor this community service project, but also from city and county health departments which are increasingly alert to the need for such a program.

During 1967, under the direction of the Wisconsin Society, preschool vision screening programs were held in 11 communities throughout the state. All programs carried the endorsement of local physicians. The Society was responsible for all program organization and direction and training of the service group volunteers who did the actual screening of the children. In each program a comprehensive follow-up was performed on all referred children by the sponsoring service organization and local health department. All final statistics are not yet available but here are a few figures to point up the success of a young, growing program: 4,025 children, ages 3 through 6 years, were screened with 136 being referred for a professional eye examination; 377 trained volunteers put in approximately 3,538 hours to accomplish this task.

New programs are being organized every month in different state areas with existing ones being conducted on an annual basis. This is a good example of a community service being rendered by cooperation between public and private agencies in a project no single group could easily accomplish, eliminating the need of expending local or state public funds for such a purpose.—RALPH E. TEITGEN, M.D., Chairman, Medical Advisory Committee, WSPB, Inc., 312 East Wisconsin Ave., Milwaukee, Wis. 53202.

UW STUDY OF DIABETIC RETINOPATHY

Dr. Frank Myers, who recently completed a residency in ophthalmology at the University of Wisconsin, has been awarded a fellowship by the National Institute of Neurological Diseases and Blindness for study of diabetic retinopathy with Dr. Matthew D. Davis. Current emphasis is being placed on evaluation of photocoagulation in patients with neovascularization on the surface of the retina. Patients with early retinopathy are being studied with fluorescein angiography, perimetry, and electroretinography in an attempt to correlate structural and functional abnormalities and to document their natural progression. Referral of diabetics with early retinopathy who might be available for study for a number of years would be welcomed, as would patients with early neovascular proliferation on the surface of the retina.

RESEARCH EQUIPMENT FUND

In July 1966, the Milwaukee Ophthalmic Institute made plans for a limited fund drive for $50,000 in order to assist the Department of Ophthalmology, Marquette School of Medicine, equip several research laboratories, which were ready to operate except for expensive equipment. The drive was started in September 1966 and by Feb. 1, 1967, the fund was oversubscribed. With the exception of one Federal grant and one anonymous donor, all money donated to this fund came from Wisconsin individuals, corporations, and foundations. The equipment in large part has already been purchased and the research laboratories are now functioning.

—JOHN B. HITZ, M.D.

MINUTES OF COUNCIL MEETING

MADISON, MARCH 9–10, 1968

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:25 p.m. on Saturday, Mar. 9, 1968, at the State Medical Society.

Voting members present: Doctors Bayley, Schulz, Nordby, Carey, Boren, McRoberts, Ludwig, Manz, Egan, Sullivan, Houghton, Van Hecke, Chojnacki, Hollenbeck, Wright, and President Kief; present Saturday only, Doctors Stoops, Huth, Fox, and Past President Drew.

Others present: President-elect James, Vice-speaker Nereim; AMA delegates Bernhart and Galasinski, Saturday only, and alternate delegate Picard; Doctor Simenstad; Messrs. Crownhart, Koenig, Thayer, Brower, Reynolds, Maroney, LaBissoniere, Murphy, and White; Gill, Kluwin and Tiffany, Saturday only; Johnson and Miller, Sunday only; Mrs. Anderson, Misses Cordts and Pyre.

Present for special orders: Dr. Henry Peters, Saturday, Dr. George Murphy, Sunday.

2. Approval of Minutes

On motion of Doctors Chojnacki–Schulz, carried, the minutes of the Nov. 4, 1967, Council meeting were approved with the clarification that the salary increase for the Insurance Director was retroactive to Jan. 1, 1967.

3. Nicaragua Medical Society

Dr. Henry Peters accepted with appropriate comments a plaque to be taken to the Nicaragua Medical Society which incorporated the resolution adopted by the Council in 1967, offering assistance in the organization of a Nicaragua Medical Society. Nicaragua is Wisconsin's sister state through the Alliance for Progress.

4. Report of Joint Meeting of Executive Committees of the Council and of the Commission on Medical Care Plans, Jan. 20, 1968

A. Payment for Drugs under Title XIX—Medicaid

The Council considered a joint report of the two executive committees which stated, in substance, that the current ruling of the Board of Health and Social Services on the matter of paying for drugs dispensed by physicians under Medicaid was not in the best public health interest.

The ruling of the Board is to the effect that where drugstore facilities are inadequate, physicians will be reimbursed a usual, customary and reasonable fee not to exceed $2 per prescription. If adequate facilities exist, the physician who dispenses will be reimbursed cost plus 10%.

The two executive committees emphasized that the physician, in dispensing, is performing a medical service and should be compensated as for other professional services, i.e., a usual, customary and reasonable fee, and this regardless of the circumstances demanding the services.

Motions were offered by Doctors Schulz–Stoops and Sullivan–Hollenbeck which the Secretary interprets as recording the Council to the effect that:

1. Physicians in the dispensing of drugs are providing a professional medical service and should be compensated a "usual, customary and reasonable" fee therefor.
2. While not conceded, it may be within the authority of the State Board of Health and Social Services to determine under what circumstances a professional medical service may be provided.
3. The welfare of the patient is of prime consideration.
4. An arbitrary "markup" is not consistent with the determination of a "usual, customary and reasonable" fee, and may be either excessive or oppressive to patient welfare in some circumstances.

B. Consultant Physicians in Pathology and P.L. 89–97

Doctor Richards had presented the position to the two committees that this group of pathologists wishes to be recognized as privately practicing consulting physicians, and does not constitute a commercial laboratory subject to regulations of the Department of HEW in order for patients using their services to be reimbursed under Medicare. He pointed out that such a governmental ruling could very well be a precedent for later application to other segments of medicine.

The committees recommended that the Council on Health and members of the State Board of Health and Social Services be requested to evaluate the effect and precedent of this type of ruling, which does not accommodate special situations such as the Consultant Physicians in Pathology present, and take appropriate action, the intent being that if the state agencies are in disagreement with the federal ruling, an effort can at least be attempted to secure an amendment to permit a group of consulting physicians to be recognized as are other physicians.

Doctors Bayley–Schulz moved that the recommendation be approved, and after discussion, Doctors Sullivan–Van Hecke moved that the matter be referred to the Section on Pathology for its opinion and recommendation to the Council. The motion to refer carried.

C. Blue Cross Association Research Study Proposal

Approval of the Society had been requested to a proposed study of utilization of existing home care programs of hospitals in Madison and Milwaukee.

On advice that the project has been dropped for the present by its proponents, the request was tabled on motion of Doctors Sullivan–Huth, carried.

D. Chapter 76, Laws of Wisconsin, 1967

On motion of Doctors Nordby–Ludwig, carried, the Council approved the following resolution relating to chiropody (podiatry) and health insurance benefits:

Resolved, That the Commission on Medical Care Plans recommend to the Council that the Secretary–General Manager and the Insurance Director be jointly authorized to conduct an immediate study of the means available for correcting legislatively or challenging the validity, or both, of Chapter 76, Laws of Wisconsin, 1967, which establishes a principle serious in its implications to the general public and to sound health insurance programs as well; and be it further

Resolved, That if the Council approves such study, the Secretary–General Manager and the In-

surance Director be authorized to seek whatever technical advice is deemed necessary; that they report their joint recommendations to the Council as soon as practical; and that the Commission on Medical Care Plans also be kept informed of developments; and be it finally

Resolved, That pending a decision by the Council on the procedures to be followed and the completion of the steps authorized by it to correct the situation presented by this legislation, and as a matter of fairness to subscribers, WPS continue, as a matter of administrative discretion, to pay claims submitted under this law.

E. National Blue Shield Equalization Agreement

Mr. Tiffany explained the concern of WPS over the currently proposed agreement relating to national account enrollment which all plans were being asked to sign, by which they in effect abdicate control over rates and commit their reserves to make up any deficit due to bad experience no matter in which state it might occur. He said that methods were under study whereby WPS might sign the agreement, but with certain protective reservations.

5. Bylaw Amendment

On motion of Doctors Hollenbeck–Carey, carried, the Council forwarded to the House of Delegates proposed revisions in Chapter XI, Sec. 3, to effectuate the provision that county society membership be based on a physician's place of principal practice rather than residence.

6. WMJ Editorial Policy

Comment had been received over a recent "guest editorial," and question was raised as to what review editorials receive before printing. The Council was reminded that in electing the editorial director, it expressed confidence in him, and the JOURNAL does carry the statement that the views expressed in editorials, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Editorials and the President's Pages are reviewed by the Secretary in relation to libel laws and stated policy of the Society.

The intention in printing the "guest editorial" in question, admittedly a minority view, was to stimulate interest in the forthcoming Town and Gown Symposium.

7. Herman Heise, M.D.

On motion of Doctors Egan–Schulz, carried, the Council endorsed the recommendation of the Commission on Safe Transportation that Doctor Heise be commended for his efforts on behalf of safe transportation in the State of Wisconsin.

8. Fifty Year Club Eligibility

On motion of Doctors Hollenbeck–McRoberts, carried, the Council approved extension of eligibility to physicians fifty years after graduation from medical school, eliminating the requirement that they still be in active practice.

9. Division of Scientific Services

Mr. Reynolds gave an informational report on office activities in the area of scientific services, including annual meeting preparations, "in-depth" teaching programs, scientific speakers service, and the Town and Gown Symposium.

10. Report by Legal Counsel

As background information in consideration of the matter of classification of hospital emergency facilities, Mr. Kluwin commented on physicians' emergency service plans in operation in at least two hospitals in the state which utilize a billing service in Michigan, and which had recently received attention in the press.

Mr. Murphy reviewed some of the major legal matters of current interest, such as the podiatry legislation earlier referred to, the problem of governmental administrative rulings put into effect without a hearing, such as that relating to drugs under Title XIX, and keeping watch on the work of the legislative committee revising the insurance code.

He also reviewed the subject of nontherapeutic sterilization, the only law in the state being a series of opinions of the attorney general dating back 30 years, and while legislation had been drafted last year, none reached the floor. He reported that the opinion requested by the State Board of Medical Examiners in 1966 and again last year still has not been released. He suggested that the Council report the status of this matter to the House of Delegates.

On motion of Doctors Chojnacki–Ludwig, carried, the Council requested that such report be made to the House of Delegates.

11. Reports to House of Delegates

The Council discussed present procedures of submitting committee reports for review by it or the Executive Committee before they are distributed to the House of Delegates, and in recent years this has included reports of standing committees of the House as well as those which report through the Council. The practical difficulty of completing committee business and preparing reports in time for a February or March Council meeting was recognized, and to withhold them from distribution to delegates in advance of the annual meeting results in too much material to absorb at the time of the House sessions.

On motion of Doctors Sullivan–Chojnacki, carried, the Council authorized automatic forwarding of committee reports to the House of Delegates unless the staff finds some question of policy that requires clearance.

12. Report of AMA Delegation

Doctor Bernhart highlighted actions at the Clinical Convention in Houston, including disposition of the three resolutions introduced by Wisconsin. Actions have been published elsewhere and are not repeated here. He also said that L. O. Simenstad, M.D., would be promoted for reelection to the AMA board of trustees.

13. Report of Planning Committee

The Council took action as follows on recommendations of the Planning Committee.

A. Medical Student Liaison

(1) On motion of Doctors Manz–Schulz, carried, the officers of the SAMA chapters and their medical advisors will be invited to a Council meeting held at the Society.

(2) On motion of Doctors Sullivan–Hollenbeck, carried, functions for the graduating classes of both Wisconsin medical schools were authorized, the total cost estimated at up to $1,000.

B. Medical and Ancillary Health Manpower

On motion of Doctors Houghton–Schulz, carried, the Council approved the recommendations that the Wisconsin Health Council, of which the Society is a charter member, investigate the possibility of developing a comprehensive program of interesting students in medical and allied health fields under the financial auspices of the Regional Medical Program, Inc.; and that the State Medical Society and its Auxiliary continue current efforts in career weeks for high school students and other programs presently being conducted.

C. Secretary's Report to House of Delegates—May 1967

On motion of Doctors Chojnacki–McRoberts, carried, the Council requested the delegates to the AMA to introduce proper resolutions to implement the report at the national level.

D. Bowling Tournament

On motion of Doctors Egan–Hollenbeck, carried, the Council approved establishment of an annual bowling tournament for the Society and its Auxiliary each February beginning in 1969. It was anticipated this will become self-sustaining after it is given impetus.

E. Committee on Medicine and Religion

On motion of Doctors Chojnacki–Huth, carried, the Council authorized appointment by the chairman of a Committee on Medicine and Religion.

The Council recessed at this point, reconvened Sunday morning as members of the SMS Realty Corporation, then resumed consideration of the Council agenda, Vice-chairman Nordby presiding.

14. Classification of Hospital Emergency Facilities

Doctor Murphy, chairman of the Commission on Hospital Relations and Medical Education, discussed its proposed classification of hospital emergency facilities in Wisconsin into one of four categories, depending upon facilities and personnel available: first aid room, limited emergency service room, full-fledged emergency service room, or trauma unit. It is intended that they be so "labeled" for public understanding of their extent or limitations in event of traffic accidents or other emergencies. He indicated that there is no mandate that this be done at present, but suggested it might be done voluntarily through the Division of Health and state trauma committee of the American College of Surgeons. In discussion, question was raised as to possible legal implications in classifying emergency facilities.

Doctor Murphy also suggested some other possible measures in a traffic safety plan for the state, and specifically a resolution encouraging the state school system to require first aid training as part of the driver education course.

On motion of Doctors Egan–Schulz, carried, the Council commended the Commission on Hospital Relations and Medical Education and the Commission on Safe Transportation for their activities; expressed its interest in pursuing this matter further; and requested that after consideration of various factors involved, the Commission bring in formal resolutions for the Council to act upon.

15. Report of Finance Committee

A. 1968 Operating Budget—General Fund

On motion of Doctors Chojnacki–Schulz carried, the Council accepted the budget as proposed by the Finance Committee.

B. Presidential Per Diem

The Finance Committee had considered, at the suggestion of the House of Delegates, establishment of a per diem for the president during his term of office, but recommended continuation of the present system of billing the Society for actual expenses or financial needs as they arise in connection with or from the impact of Society business.

On motion of Doctors Schulz–McRoberts, carried, the Council approved the recommendation.

C. Physician Members Attending National Conferences

In considering requests of physicians to attend national meetings, either as officers or as a representative of a Society committee, the Finance Committee recommended that advance authorization be secured from the Executive Committee as at present.

On motion of Doctors Houghton–Wright carried, this policy was approved.

D. Executive Salaries and Classifications

In executive session, the Council approved salary increases for C. H. Crownhart, Secretary and General Manager, and J. P. Lockerbie, Sales Director, as recommended by the Advisory Committee on Executive Compensation and the Finance Committee.

It also approved classification of Messrs. D. C. Reynolds and H. O. Brower as associate secretaries, and H. B. Maroney as assistant secretary.

16. John H. Houghton, M.D.

On motion of Doctor Egan, variously seconded, the Council adopted the following resolution:

Resolved, That the Council of the State Medical Society of Wisconsin express its deep appreciation for the donation of a sum of money to the CES Foundation by John H. Houghton, M.D., past president, to support an annual award to an outstanding medical student in Wisconsin.

17. Report of Executive Committee

Doctor Kief reported the following items for action or information:

A. Presidential Citation

On motion of Doctor Sullivan, seconded and unanimously carried, the Council approved the nomination of Mr. Leo Massopust to receive the Presidential Citation at the 1968 Annual Meeting.

B. Governor's Task Force on Medical Education

It had been suggested that the full report be published in a series of articles in the JOURNAL. The Executive Committee recommended that only the summary be published, with information on where interested members might secure the full report.

On motion of Doctors Houghton–Wright, carried, the recommendation was approved.

C. Special Pages in Wisconsin Medical Journal

The Executive Committee recommended that there be no official billing for JOURNAL contents contributed by specialty or other groups, such as that of the Section on Ophthalmology, but if such groups wish to make a voluntary contribution to the JOURNAL, such contributions may be accepted through the Commission on Scientific Medicine.

On motion of Doctors Wright–Ludwig, carried, the recommendation was approved.

D. 1968 Wisconsin Work Week of Health

Mr. Thayer presented tentative program plans which will be supervised by the Executive Committee, with an ad hoc committee including some educators to assist in the planning since it will be directed primarily to school children.

E. Attendance at National Conferences

The committee reported authorizing J. L. Weygandt, M.D., to attend an invitational automotive safety conference in Washington, D. C., and J. C. H. Russell, M.D., to attend the annual school health conference in Chicago.

18. Special Report of President and Secretary

Doctor Kief and Secretary Crownhart discussed their concern over protecting the interests of the public and of medicine as a whole in the many health planning activities being conducted in the state with federal grants, and their belief that some means must be found to augment present staff and dues structure to do the necessary research, establish liaison, etc., to serve the profession adequately. It was proposed that through the CES Foundation, whose Executive Committee is representative of the Society itself, there be worked out an application for a federal grant to fund such a project which will last a decade or more.

On motion of Doctor McRoberts–Schulz, carried, the Council approved the proposal for implementation through the Foundation of the State Medical Society.

19. Advisory Committee on Utilization Review

The Council had requested establishment of such a committee through the Commission on Medical Care Plans. Its chairman, Dr. Paul Mason, asked that it be enlarged from the present five to provide broader geographic representation, and proposed that it become more active in developing and providing educational materials. This was approved on motion of Doctors Schulz–Wright, carried.

20. Adjournment

The meeting adjourned at 12:15 p.m. on Mar. 10, 1968.

Respectfully submitted,

C. H. Crownhart
Secretary

Approved:
James C. Fox, M.D.
Chairman

(Subject to formal approval by the Council.)

MARTIN LUTHER KING MEMORIAL FUND

The University of Wisconsin in memorium to Dr. Martin Luther King is taking up a Memorial Collection for a Martin Luther King Memorial Fund. We realize the inadequacy of words and actions at this time, yet we also believe that some form of expression needs to be made. By doing this we cannot absolve ourselves or make up for the so many injustices, but this step can be meaningful if it can further the aims and the goals for which Dr. Martin Luther King lived.

We realize that a great part of the problem is within ourselves and our own communities, and for us that specifically means the University and Madison. Therefore, we resolve that:

(1) The fund will be used as a scholarship to increase the poor and minority group student enrollment on campus.

(2) The fund be allocated to students who could not otherwise attend because of financial need.

(3) The fund be administered jointly by official representation of all supporting campus organizations and by the administration through the financial aids department and the Special Students Program.

This fund will be a continuing fund and a long range effort will be made to work for the elimination of racial misunderstanding on campus and within the community. Increased programming to help high risk students from poverty areas attend the University will be sought. You, as members of the business community could afford under-privileged students a chance for increased educational and occupational opportunity. With your willingness to help and your economic power behind us, these goals can be better realized. WE NEED *YOUR* HELP.

Please send contributions to WSA Office, 507 Memorial Union, Madison, Wisconsin. CHECKS: M. L. King Memorial Fund (TAX DEDUCTIBLE).—Edward Rube, Wisconsin Student Association Human Relations Committee

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A vital question. For if early diagnosis and treatment can cure cancer, obviously regular health checkups are essential. In a survey conducted for the Society, we discovered that only 26% of those questioned had such regular checkups. But 90% said, *if their physicians told them to do so,* they would have annual checkups.

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VOLUME 67/NUMBER 6 JUNE 1968

President's Message to the House of Delegates

By WILLIAM D. JAMES, M.D.
Oconomowoc, Wisconsin

■ ANYONE WHO OWNS a television set, reads a newspaper, or spends his time meeting and treating patients, is well aware of the fact that the social order of a generation ago has undergone a significant change, and that in our time it is changing with a rapidity that is often both bewildering and frustrating. All about us we see chaos, group pitted against group, protesting against the established order—not all of it, we might add, constructive. I will not take your time to belabor the point nor recount the many problems that beset society and the medical profession today.

The demands on our professional skills have never been greater. Significant scientific discoveries and improved medical techniques combined with widespread education and mass communication create an overwhelming demand for the benefits of this new knowledge and these new techniques. As the demand increases and as our population shifts and grows, we find ourselves critically short of medical personnel and facilities. This is particularly true in localities far from the modern medical complexes; yet the people of those areas also want and need the best that modern medicine has to offer.

Presented before the House of Delegates at the 127th Annual Meeting of the State Medical Society, May 13, 1968, Milwaukee.

Perhaps because of the complexity of the problems of a changing social order, the eroding of the values and the institutions of the past, the motto of our day seems to be: "Let's not get involved." My challenge to you tonight is to get involved because, like it or not, we are involved. As physicians, we are involved in the lives of our patients, the treatment of their ills, and the alleviation of their suffering. And we also are involved in the socio-economic aspects of our profession. For this reason, I ask you to take a greater part in the activities of your Medical Society—the organization that represents your profession in helping to determine the course that changing trends shall follow.

This society has nearly 50 councils, commissions, divisions, committees and subcommittees which, along with officers and delegates, involves more than 500 members of our Society in some type of organizational activity. They give untold thousands of hours for the betterment of public health and medicine.

In spite of this example of selfless dedication for the good of our profession, there are still many Wisconsin physicians who are not active in the affairs of their Society. They are content to sit on the sidelines, worrying about the direction of medical trends and criticizing those who lead them.

I quote from the inaugural address given by Dr. George Collentine, president of The Medical Society of Milwaukee County:

> "But I throw out the challenge to every one of you to extend himself a little bit more, to forego some small pleasure or even well-earned hour of rest, to give one more ounce of your energy and intellect to the unending tasks of your society. If you think organized medicine has failed you, ask yourselves what you have done about it. Have you informed yourself about your society's structure of committees, where every item of planning and business is thrashed out in discussion and formed and reformed for action? Have you offered yourself for appointment to the committees where your special interest and abilities lie? Have you communicated your ideas and constructive criticisms to these committees, your officers, directors, councilors, delegates or your legislators?"

Let me assure you that when you leave the ranks of the spectator to become active in any group or for any cause, you will know both criticism and frustration. However, it has always been the role of the physician to remain calm in the face of crisis and confusion. Never has there been greater need for patience and perseverance. I quote from the great Dr. William Osler:

> "In the physician or surgeon, no quality takes rank with imperturbability. . . . Imperturbability means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in the face of peril."

And so, we must be in the face of confusions and contradictions of our time. To put the wisdom of Doctor Osler in more modern language, in times like these it is up to us to assert our leadership in medicine, and in the face of opposition and criticism, not to "blow our cool."

The practice of medicine is no longer pure science and technique. Because of the way society functions today, the physician finds himself necessarily involved in the socio-economic aspects of his profession. Hospital costs, insurance plans and government programs have become important considerations to us as doctors.

Because this is true, it is vital that each of us understands these aspects of medicine. It is necessary that we be able and willing to communicate medicine's point of view not only to each other but also to the general public. Therefore, I challenge you to become involved not only in the affairs of your medical society but to extend yourselves even further and to take an active role in civic affairs. If doctors speak only to doctors, we will soon find ourselves as insulated from the world around us as Boston's Beacon Hill "where the Lowells talk to the Cabots, and the Cabots talk only to God."

It is in our associations with our patients in the affairs of our communities that we learn to know them and learn to communicate with them on problems of mutual concern. And politics at all levels is important to us. In the past, it has often been the habit of physicians to take no active part in political activities and to pretend that as professional men, we physicians are removed from the hurly-burly and strife of decision-making in a democratic society. However, we need to be a part of that decision-making. We need to be in a position to influence the decisions that affect our profession.

We dare not wait until the initiative is taken completely out of our hands by other groups less well-informed and not unselfish in their goals.

I think every physician and his wife should be a member of PACE.

As I trust most of you know by now, PACE is the voluntary independent Wisconsin organization dedicated to improve government through civic education and effective political action. PACE is under the chairmanship of Doctor Gundersen of La Crosse and a Board of willing and able leaders in each congressional district. The need for individual participation in practical bipartisan political activity is now more vital than ever.

PACE activities, coupled with membership in the national organization—AMPAC—offer the physician an opportunity to discharge this responsibility and to be a better citizen in his own community.

This, then, is my message to you: Let us get involved in our Medical Society, in our communities, in politics—and let us remain calm in the face of the turmoil and the criticism that are so often the result of involvement. I quote from C. T. Hardwick, Ph.D. consulting economist to the Michigan Medical Society:

> "Physicians must take an active role in determining the direction of social movements. Spectators have little or no influence on the outcome of the race. Victory comes to those who run the race."

Some Clinical Expressions of Antibody Deficiency and Autoimmune Reactions

By WILLIAM S. MIDDLETON, M.D., Madison, Wisconsin

■ MEDICINE IS SUBJECT to marked fluctuations in many aspects of thought and practice. Although this proclivity for change undoubtedly finds its greatest expression in therapy, theories of pathogenetic mechanisms frequently receive enthusiastic and uncritical acceptance. Too commonly the cloth is overstretched in the effort to cover totally unrelated situations. Such has been the experience in so-called autoimmune diseases. To the purist, the very designation has been anathema. Certainly from the etymological standpoint, the term is contradictory. While substitutes, such as autoallergy and autosensitivity have been offered, usage has entrenched the less exact nomenclature in these conditions.

Antibody deficiency is the basic fault in many of the conditions to which attention is herein directed. On tenuous grounds, objections have been raised to the inclusion of disorders as autoimmune or antibody deficient expressions, when an infectious, chemical, or other extraneous background can be assigned as the initiating factor. At the present time, with such a diversity of opinions among students of the subject, clarification of certain basic principles and a reconciliation of contradictory evidence will be required for clinical guidance. Meanwhile, we are well advised to adhere to certain criteria for the inclusion of disease expressions as autoimmune or antibody deficient manifestations and to avoid the reprehensible temptation of "lumping" poorly defined clinical entities under this convenient, if inappropriate, blanket.

Undoubtedly, the renewed interest in this area stems in a considerable measure from the rejection phenomena of organ transplants. The lessons learned in skin grafting had to be extended, when the transplantation of kidneys and other organs was undertaken in the experimental animal and man. The role of the thymus and the lymphocyte in the immune reaction has been the subject of detailed study for a number of years. Bunting and Huston (1921) found that more lymphocytes enter the blood stream from the thoracic duct in 24 hours than are present in the total blood at a given time. The gastrointestinal tract is the major point of exit of the lymphocytes. Bunting (1925) made further basic observations bearing on the present question. Speaking of infectious processes, he wrote that "if in great intensity, the toxins cause necrosis of the lymphocytes; if in proper dilution, one finds not necrosis but stimulation and proliferation, with the production of antibodies." From his extended studies on the lymphocyte, Bunting (1935) concluded that diseases with a lasting immunity have a definite lymphocytosis at some point in their course. He reasoned that the infectious antigen exercises its influence on the progenitors of the mature lymphocytes and successive crops of such cells possess the immune properties of their precursors.

The theory of the antigen–antibody interaction as the direct response of the host cells to a foreign invader held sway until the clone selection theory of Burnet came to dominate immunological thinking. According to this theory, the antigen has no capacity to impress a pattern on the antibody-producing cells. This function of certain clones of mesenchymal cells is genetically derived. Early in embryonic life such clones react to potential antigenic determinants of the body. As they are immunologically competent, their reaction leads to many mutations. Mutation occurs in the mesenchymal cells. Such clones as are eliminated, are termed "forbidden clones" and their interchange with antigenic determinants on this score, "forbidden patterns." These mutant forms may attach to normal tissue to induce autoimmune or antibody deficient reactions. To the resultant progeny of reacting cells or immunocytes, there is given the capacity to distinguish between "self" and "non-self."

Doctor Middleton is Emeritus Dean, University of Wisconsin Medical School, and retired Medical Director, Veterans Administration. He currently is medical consultant to the Veterans Administration Hospital, Madison.

A breakdown of the information center results in a failure to eliminate forbidden clones. "From the time of birth there is in the body an adequate supply of information to allow the recognition of vast numbers of antigenic configurations" on this basis. The flow of information is always from the genetic to the biochemical base. Significantly, in adult life instead of disintegration and elimination of the immunologically competent cells (immunocytes) in reaction to the antigenic determinant, proliferation of these clones may ensue in the spleen, lymph nodes, and bone marrow.

Evidence supports the contention that the stem cell of mesenchymal tissue is the ultimate source of the immunologically active clones. In the present relation the lymphocyte is most important. The disproportional size of its nuclear mass would seem to portend its importance in nucleic acid synthesis and the sequence from desoxyribonucleic acid (DNA) to ribonucleic acid (RNA) to protein ensues. In essence the lymphocyte, whatever its subsidiary functions, is the bearer of immunological information. The macrophage may reduce the concentration of antigen and thus limit its capacity to submerge the function of the antibody-producing cells. The plasma cell is the primary source of antibodies. The NZB mice have proven an invaluable experimental model. The sequence of histological changes finds the activated stem cell, presumably resistant to normal control, proliferating. Clones of lymphoblasts appear in the germinal centers. Small lymphocytes develop from the periphery and accumulate with depletion beyond this zone. Later, the germinal center loses its discreteness and becomes a mass of small and medium lymphocytes. In the mouse, while healthy, the thymus may produce new germinal centers. Significantly the transfer of living spleen cells from the affected adult NZB mice to isologous young mice induces positive Coombs' test and LE cells in the latter. The immune response may be traced to the pyronin-staining cells of the lymph nodes, spleen, and Peyer's patches.

In chickens, the bursa of Fabricius and the thymus have been established as the primary sites of origin of these cells. The lymphocytes which arise from the bursa of Fabricius, are the precursors of the antibody-producing cells. The thymus controls the production of small lymphocytes which are responsible for delayed hypersensitivity and homograft rejection. In man, the tonsils and Peyer's patches are assumed on limited evidence to be the counterpart of the bursa of Fabricius, while the thymus significantly controls some aspects of antibody formation and graft rejection. Experiments of an involved order employing labelled pyrimidine, among other models, are steadily extending our knowledge of this involved field.

The antibodies in human serum are found only in the immune gammaglobulins, of which there are three families with common characteristics of antigenic sites and structural subunits but with distinctive physical and chemical properties. Their migration in an electric field places them in the gamma classification, although there may occasionally be a movement to the beta and alpha positions. The total gammaglobulin is higher in the non-Caucasian adult male than in the Caucasian. In the latter, the three gammaglobulins are gamma G (7S gamma or gamma 2) that constitutes 71% of the total or 1.26 gm/100 ml of blood serum, gamma A (gamma 2A), 21% and gamma M (macrogammaglobulin-19S, beta$_2$M), 6.5%. The genetic basis of their production and the serologic changes that reflect the impact of disease on this basic immunologic mechanism, have received wide attention in the laboratory and clinic. Agammaglobulinemia has afforded a fortuitous key to the solution of certain problems in this area. Certainly the failure of its subjects to respond to any antigen (universal tolerance) suggests a mutation in the formation of ribonucleic acid. The extract of the kidney bean has been used to demonstrate the marked difference between the reaction of the normal lymphocytes and those in agammaglobulinemic subjects. By the phytohemagglutinin test (PHA), such extracts induce mitosis in the circulating lymphocytes of normal subjects. In agammaglobulinemia, like changes are observed; but there are no added proteins and, on exposure to antihuman gammaglobulin, the lymphocytes show no immunofluorescent staining. It may be concluded that the antigens are the cause and not the result of the defect in the plasma cells in agammaglobulinemia.

The field of autoimmune and antibody deficient reactions is so broad that only char-

acteristic examples of diseases with a dominance of such responses may be discussed in the present connection. By common consent, acquired hemolytic anemia, typifies this situation. Certain authorities hold the direct Coombs' test the hallmark of this condition. Under the clone selection theory, with or without a recognized pathologic background as lymphocytic leukemia, lymphoma, myeloma, ovarian cyst or lupus erythematosis disseminatus, this condition represents a breakdown of normal homeostasis that would have assured the elimination of "forbidden clones." Instead, these mutant cells proliferate in the lymph nodes and spleen. Their abnormal gammaglobulin coats the red blood cells and, by their injury, creates the prospect of further antigens in a vicious circle. The autoantibodies are of two types; i.e., a "warm" type of low molecular weight and 7 S and a "cold" type 19 S that combines with human red blood cells at low temperature. The experimental counterpart may be produced in guinea pigs by the injection of antiguinea pig-erythrocyte rabbit serum. The studies of the marrow disclose normoblastic hyperplasia, normal granulocytic and megakaryocytic regeneration. Erythrophagocytosis may be observed in the marrow, spleen, lymph nodes, and liver. Splenomegaly is the rule in acute hemolytic episodes, but may be lacking in its chronic course. Hemosiderosis is anticipated.

Clinically, the hemolytic crisis is heralded by chills, fever, and backache. Anemia of different degrees may lead to all of the constitutional and organic manifestations of anemia of any origin. The release of hemoglobin may seriously compromise renal function. From hemoglobinemic nephrosis, oliguria may be succeeded by frank uremia. This situation is more apt to supervene if arterial hypotension develops. Jaundice is not attended by pruritus. As stated, splenomegaly is the rule. Raynaud's phenomenon is common. The complication of thrombophlebitis is especially serious.

As indicated, the direct Coombs' test is always positive. The diagnosis of acquired hemolytic anemia cannot be made in its absence. Macrocytosis characterizes the erythrocytes. In general, its degree parallels the reticulocytosis. Decline of the latter with persistence of hemolysis bespeaks a bad prognosis in the failure of the marrow. Normoblasts, conversely, bespeak a sustained regenerative capacity in the marrow, as do tintorial changes in the erythrocytes. Occasionally Howell–Jolly bodies and spherocytes are encountered. Leukopenia and thrombocytopenia may be anticipated. Excesses of urinary and fecal urobilin appear in hemolytic crises. Special studies will be dictated by precipitating factors as cold, syphilis, lymphomata, and other diseases in which acquired hemolytic anemia occurs.

The prognosis of acquired hemolytic anemia depends upon the control of its underlying etiology. Where it can be eliminated or controlled, the outlook is favorable. Occurring in childhood or as an unusual complication of atypical pneumonia (mycoplasma pneumoniae) and infectious mononucleosis, the prognosis is likewise favorable.

The treatment of this condition is first directed toward the primary disease. Otherwise steroids have the first call. Prednisone, in doses of 10 to 15 mg every six hours, is recommended. If the situation be critical, hydrocortisone, 200 to 300 mg, should be given intravenously. If conditions do not amend under steroid therapy, splenectomy may be considered. Its removal does not alter the immunologic fault; but the sequestration and the hemolysis in the spleen are eliminated, usually with clinical improvement. Furthermore, a singular by-product of splenectomy has been widely observed. Almost without exception, the steroids are more effective in these splenectomized patients. Alkylating agents and antimetabolites have occasionally been beneficial in arresting the immunological disturbance. Nitrogen mustard, 6-mercaptopurine, imuran, and antilymphocyte serum may have an increasing place in its treatment. Transfusions of fresh blood may bridge crises. Coumadin preparations are indicated in complicating thrombophlebitis. Unless contraindicated, in such patients the prothrombin level should be kept between 20% and 30%. Cold must be avoided, if this be the inciting factor. Tocopherol is the latest therapeutic recruit. Presumably vitamin E operates through its correction of the deficit that may affect lipid movement across the erythrocyte cell membrane.

Unusual interest attaches to certain immunological observations in pernicious anemia and atrophic gastritis. In one study, 62 of 72 patients with pernicious anemia

(86%) showed immunofluoresence in the gamma G globulin fraction of their sera. A similar but lesser response was noted in the gastric juice of these patients. Immunoglobulins were demonstrated in the mononuclear cells of the lamina propria of the gastric mucosa of these patients. Parietal cell and intrinsic factor antibodies have been separately identified in patients with pernicious anemia. By immunofluorescent staining, up to 87% of such patients have exhibited this reaction in the parietal cells. The immune antibody is 7S gamma globulin. The fact that 14.5% of the kin of patients with pernicious anemia have this specific antibody, raises the question of a genetic connection. If such be the case, the trait is probably a dominant gene with incomplete penetrance.

Doig and his associates (1957) observed a reversion of megaloblastic to normoblastic regeneration in the marrow of three of four pernicious anemia patients receiving prednisolone. Parallel reticulocytosis and increases in hemoglobin and red blood cells attended the marrow reaction. Among others, Jeffries et al (1966) extended these observations in six patients with pernicious anemia, one with latent pernicious anemia and one with atrophic gastritis. Prednisolone in doses of 10 to 40 mg a day was continued from two to eight months. The patients with pernicious anemia maintained their conventional routine of Vitamin B_{12}, 100 mcg intramuscularly at monthly intervals. Upon biopsy, the controls disclosed atrophy, lymphocytic and plasmocytic infiltration of the gastric mucosa. The lining epithelium, while atrophic, had a singular cuboidal form. Areas of local and diffuse intestinal metaplasia were seen. With a single exception, no parietal cells were recognized. After prednisolone, parietal and chief cells reappeared but the architecture was not restored. Free hydrochloric acid and intrinsic factor returned to the gastric juice. Although the parietal cell antibody did not decrease, B_{12} absorption was increased and the clinical and hematological response was unmistakable. An interesting detail relates to the failure of any improvement in B_{12} absorption on the administration of prednisolone to gastrectomized patients.

While the case for an autoimmune mechanism in the pathogenesis of pernicious anemia has not been conclusively made, the existence of antibodies for the intrinsic factor and for the parietal cells is unequivocal. The response to prednisolone bespeaks the interruption of an abnormal immune reaction that destroys the gastric mucosa. The sustained suppression of the immune process favors the regeneration of the gastric glands with the results outlined. Conceivably this evidence would justify the use of prednisolone in a protective role in latent pernicious anemia; but there is no indication for its replacement of Vitamin B_{12} in the active therapy of this condition.

Hashimoto's disease was one of the first to fulfill the criteria for its classification as an autoimmune disorder. Roitt and associates (1956) were impressed by the high serum gamma globulin with abnormal hepatic flocculation tests in patients with large goiters. After thyroidectomy such abnormalities returned to normal in a majority of instances. These circumstances coupled with the characteristic lymphocytic and plasma cell infiltration of the thyroid gland raised the question of an immune reaction. By studies of the precipitin reaction between the sera of patients with Hashimoto's disease and the saline extract of the normal thyroid gland, sera of Hashimoto's subjects proved positive. The controls, i.e., brain, liver, kidney, spleen, lymph nodes, and parotid glands, were uniformly negative. Nor were thyroid glands of heterologous species positive. In other studies, 32 of 35 rabbits developed autoantibodies on the injection of a saline extract of rabbit thyroid. The structural changes in the thyroid gland closely paralleled the human experience. This experiment has been repeated in guinea pigs and dogs with similar results. In patients with chronic thyroiditis, specific circulating antibodies against extracts of human thyroid tissue have been demonstrated. As in experimental animals, the thyroglobulin is the target. So there develops an autoimmune reaction of the host against his own thyroid. In this process the thyroid autoantibodies serve both as indicators and as links in the pathologic process.

The distribution of connective tissue and its participation in vital processes through the interstitial circulation should make its constituents especially vulnerable to autoimmune and antibody deficient processes. Perhaps, based upon the clone selection theory, one of the most obvious occasions for

involvement of the connective tissue elements in autoimmune and antibody deficient processes, namely mutation, leads to such a multitude of antibodies as to confuse the issue. Lupus erythematosis disseminatus may be taken as a classical example of a diffuse connective tissue disease. In the simplest expression, such patients have abnormal gammaglobulins circulating in the blood to act as antibodies. Encountering their type specific antigen, if it be attached to a cell, the autoimmune reaction ensues. Indeed, its reaction to the native nuclei of cells is an established evidence of an antinuclear antibody. Such a sequence accounts for hemolytic anemia and a wide spectrum of clinical variants in DLE. Damashek (1958), in assigning an autoimmune responsibility for DLE, grouped its complex manifestations under two general headings; i.e., mesenchymal and hematologic. Under the former, he listed involvement of the joints, pleura, pericardium, endocardium, glomeruli, skin, spleen, etc., through changes in the endothelium of the small vessels. The elements of the blood that may be compromised, include red blood cells, (Coombs' positive hemolytic anemia), white blood cells (leukopenia; LE cells), platelets (thrombocytopenia purpura), coagulation faults (hemophilia; hypoprothrombinemia), syphilitic antibody. To these details from a pathologic standpoint should be added involvement of the central nervous system, kidney, and spleen. The LE cell which has broadened the prospect in this area, represents an abnormal autoantibody to some constituent of the nucleus of the leukocytes. In this disease there are other circulating antinuclear antibodies with sediment coefficients of 7S and 19S. Complement fixation and immunofluorescence are valuable aids to their demonstration. Unfortunately the LE cell is not regularly reproducible experimentally; but in the NZB mice and in humans with an LE-like reaction to hydralazine, penicillin, foreign serum, procain amide and other substances, there are models that tempt the immunochemist.

Lupoid hepatitis has been the subject of much discussion and study. In the opinion of many, it represents a special form or sequel of viral hepatitis. Others adhere firmly to the position that it is a separate entity. Its clinical course is arresting. The onset, in adolescent or young adult women almost exclusively, is very insidious with mild jaundice. Arthralgia and vesicular or maculopapular eruptions may appear. Complicating serous membrane and renal involvements accentuate its gravity. Positive latex, sheep red cell agglutination and antinuclear antibodies on fluorescence may appear. Most significant is the high incidence of LE cells (14 of 19 cases in one series); but there have been reported no instances of autoantibodies against specific liver antigens.

Until the advent of steroids in the treatment of DLE, this disease ran its inexorably fatal course with occasional unexplained remissions. While it is true that the definition of the LE cell widened the diagnostic base, it is nonetheless evident that the disease has a much broader spectrum of organ involvement and gravity than once suspected. With due allowance for these variables, the corticosteroids have materially modified its course. For the ordinary subject, prednisone should be started at 60 mg a day and the dose adjusted downwards by small decrements to control the local and constitutional manifestations. As a rule, the physician will be well-advised to continue the steroid regimen for two to three months beyond the period of control. In emergent situations or where the steroid cannot sustain the plateau of improvement, adrenocortical hormone (ACTH) may prove life-saving. The recommended dose is 25 mg in 500 ml of normal saline given intravenously over a period of four hours. As in acquired hemolytic anemia, immunosuppression may be invoked in critical or deteriorating stages of the disease by the use of nitrogen mustard, 6-mercaptopurine, imuran or antilymphocyte serum. These measures may control the more serious aspects of DLE; but they are not curative. Atabrine and chloroquine have a restricted usefulness in this condition.

As stated, the entire group of connective tissue diseases has some claim for individual inclusion as autoimmune or antibody deficient disorders. Certainly diffuse systemic sclerosis, Sjögren's disease, rheumatoid arthritis, and dermatomyositis present features that might be so considered. It is especially interesting to note the association of thyroiditis, Addison's disease, DLE, rheumatoid arthritis, diffuse systemic sclerosis, thymic disturbance, myasthenia gravis, colitis, and other disorders in various combinations in the same patients. In the association of

dermatomyositis with neoplastic disorders, it is postulated that antigens of neoplastic cells set up a reaction in a forbidden clone to produce autoantibodies against normal tissue. If evidence establishes this thesis, obviously the neuropathies and myopathies in neoplastic patients may prove to have a similar explanation. One of the most intriguing of recent inclusions in this group is the suggestion that postvalvular surgery syndromes rise from the reaction to the foreign substance introduced with the formation of an erythrocyte antibody. Extreme turbulence of the blood stream may add to the situation. The occasional occurrences of rheumatoid arthritis in patients with agammaglobulinemia may be explained on qualitative as well as quantitative grounds, if the former condition be established as an autoimmune disease.

So the boundaries of accepted autoimmune and antibody deficient reactions and diseases are being extended. In a broad sense, many of the manifestations of diseases, infectious, metabolic, neoplastic, may represent the disturbance of balance (homeostasis) setting in play forces that initiate the development of forbidden clones. These in turn may produce gammaglobulins of an unusual order. Since communication through the normal channels of RNA information is broken, the distinction of self and non-self is lost and normal tissue may suffer. In this extended concept, autoimmune and antibody deficient reactions, rather than autoimmune and antibody deficient disease, take a much wider significance. The role of the complement in these conditions requires special evaluation.

CASE REPORT

Perforation of a Duodenal Diverticulum

By HENRY S. WATERS, M.D., F.A.C.S., and ETHAN D. PFEFFERKORN, M.D., Marshfield, Wisconsin

■ DIVERTICULA OF THE DUODENUM are well known to the medical profession, but most of us tend to regard them clinically as asymptomatic and harmless. This is a case report of perforation of a duodenal diverticulum with acute symptoms, serious complications, and successful surgical intervention.

Such a complication, while extremely rare, is not altogether unknown. Graves et al[1] collected a total of 23 cases reported in the literature of the United States, Great Britain, and Europe. To these they added 2 cases of their own to make 25 known cases of perforation of a duodenal diverticulum. There was an overall mortality of 44%, attesting to the gravity of the condition when it does occur.

Case Report

Our patient was a 56-year-old white man. His occupation was a mechanical shovel operator. He was a non-smoker and a non-drinker, and denied any previous illness except a bilateral inguinal herniorrhaphy done four years ago. He had had no abdominal pain nor any digestive difficulty. On July 26, the day he was taken ill, he had operated his mechanical shovel all day, eaten a supper of ham, baked potato, and corn-on-the-cob, and gone to bed about 9 P.M. At 9:30 he experienced a sudden severe pain in the epigastrium, which spread rapidly over the entire abdomen. He was nauseated but did not vomit. The pain was so severe that he could not get out of bed, and he called for a physician to come to the house. One of us (E.D.P.) saw him there at about 11 P.M., made a provisional diagnosis of perforated peptic ulcer, and sent him to the hospital by ambulance. He was seen there on arrival in surgical consultation (H.S.W.). No other history than that given above could be elicited.

Physical examination showed a well-nourished, muscular man who was obviously in acute pain in spite of the 100 mg of meperidine (Demerol) given intramuscularly by the physician at the patient's home. His temperature was 98 F; pulse rate, 90; and respirations, 16 per minute. Blood pressure was 122/80 mm Hg. The head, neck, chest, and extremities showed no abnormal findings. The abdomen exhibited a board-like rigidity throughout, with exquisite tenderness in the upper half. No masses could be palpated. Bowel sounds were silent. There were bilateral inguinal herniorrhaphy scars with no recurrence of the hernias. The rectum contained a small amount of brown formed stool.

The laboratory showed a blood picture of hemoglobin 13.8 Gm/100 ml, hematocrit 40%; white blood cells 10,600 per cu mm with a differential count of 3 band forms, 64 segmented neutrophils,

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25 lymphocytes, and 8 monocytes. The urine showed a specific gravity of 1.030, negative albumin, sugar, and acetone, and microscopically 1 to 4 white blood cells per high-power field. Serum amylase was 55 Somogyi units per 100 ml. An x-ray of the abdomen, supine and upright, showed no visible stones, no free air under the diaphragm, and a gas pattern consistent with early adymanic ileus. An electrocardiogram was interpreted as within normal limits.

In spite of the absence of free air under the diaphragm, the provisional diagnosis was still perforation of a peptic ulcer. A Levine tube was inserted and gastric suction begun, intravenous dextrose in lactated Ringers solution was started, and the patient was taken to the operating room at 2 A.M., four and a half hours after the onset of symptoms. The abdomen was opened through an upper right paramedian incision, and the contents explored. There was a moderate increase of clear peritoneal fluid. There was no perforation or induration of the stomach or anterior duodenum. The appendix and gallbladder were normal, and the pancreas showed no enlargement or induration. On the right lateral (convex) side of the descending portion of the duodenum was an area of fibrinous exudate with the omentum adherent over it. The tip of the omentum showed a brownish-green discoloration and appearance of fat necrosis. On bluntly separating it from the underlying duodenal wall a blister-like protrusion was revealed, measuring about 2 cm in diameter and 1.5 cm in height with a 0.8 cm hole at its apex. Gas bubbles could be seen moving under the surrounding peritoneum and escaping through the perforation, as did one kernel of corn.

The necrotic tip of the omentum which had been adherent over the perforation was excised. A 4-inch incision was made along the postero-lateral reflection of the peritoneum to provide anterior and medial mobilization of the duodenum, and better exposure. The entire diverticulum was then excised out to normal duodenal wall, and the defect closed transversely with two layers of continuous Chromic-00 suture and a third layer of interrupted silk. Since this narrowed the lumen of the descending duodenum, it was decided to provide a bypass in the form of an anterior medium-loop gastrojejunostomy. The peritoneal cavity was then irrigated with 4 liters of saline, and the abdomen closed without drainage.

The pathologic report was: Tissue "A"—Omentum showing acute inflammation and fat necrosis; Tissue "B"—Acquired diverticulum of the duodenum showing mucosa, muscularis mucosae, and serosa, with acute peritonitis and fat necrosis.

Postoperatively the patient did surprisingly well. He was maintained on intravenous fluids and gastric suction for three days, then the Levine tube was removed, and oral feedings begun. These were well-tolerated, with no vomiting. He was out of bed on the second day, and bowels started to move spontaneously on the second day. On the ninth day an upper gastrointestinal x-ray series showed a narrowing of the second portion of the duodenum, with the contrast medium passing through it and through both arms of the gastrojejunostomy. He left the hospital on the tenth day, and has been seen several times in the office. At four weeks he was eating everything (against advice), and was back driving tractor, combine, and his shovel (also against advice), and had no abdominal pain or digestive difficulty.

Comment

A case of spontaneous perforation of a duodenal diverticulum has been reported, the 26th (to our knowledge) on record. The patient was probably fortunate in that the diverticulum was on the free lateral surface of the descending portion of the duodenum, and ruptured into the peritoneal cavity, rather than on the inner side of the C-loop, where rupture produces a retroperitoneal and peripancreatic abscess, more difficult to diagnose and to repair. Also early operation is credited with his smooth postoperative course. A plea is made for surgeons to be aware of this pathologic condition, even though rare, and bear it in mind in differential diagnosis and operative exploration for acute upper abdominal symptoms.

REFERENCE

1. Graves, H. A., Jr., Durette, D. J., Jr. and Holcomb, G. W., Jr.: Perforated duodenal diverticulitis, *Am J Surg* 112:908, 1966.

NARCOTICS REGISTRATION DEADLINE IS JULY 1

All physicians registered under the Harrison Narcotic Act or the Marihuana Tax Act must re-register and pay a tax of $1.00 by July 1. Failure to comply with the law may result in severe penalties. If you have not received forms for separate registration and inventory of narcotics and marihuana, contact the Office of the Director of Internal Revenue, Federal Building, Milwaukee 53201. Physicians with more than one office must register for each since each office is required to have a separate registration number.

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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Adrenergic Receptors and the Physician

By PITAMBAR SOMANI, M.D., Ph.D.
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■ THE CONCEPT, that molecules of various drugs combine with *specific* "receptive substance" or "receptor" in living tissue to initiate pharmacological actions, was first proposed by Langley in 1878.[1] This concept can be illustrated in its simplest form by the reaction:

$$\text{Drug} + \text{Receptor} \rightleftharpoons \text{Response.}$$

The term receptor is most often used by pharmacologists to denote the hypothetical specific molecular site in or on an effector cell with which a drug combines or reacts in order to produce a response. Evidence has accumulated in recent years that although several structurally different drugs may elicit the same overall pharmacological response, each drug reacts with only one set of specific receptors, and the drug-receptor interaction then proceeds through several specific intermediate steps for each drug (A, B, A_1, B_1, A_2, B_2, etc.) and then through some common reactions (x, y, z, etc.). The most compelling evidence for a differentiation of various hypothetical receptors comes from the use of specific blocking agents (Fig 1). With the use of a proper blocking agent, it is thus possible to antagonize selectively the given response to only one drug without modifying the same effect of other drugs.

This conceptual design for drug receptor has proved to be very useful in understanding the pharmacological actions of various drugs on the autonomic nervous system, especially from the point of view of explaining the diverse excitatory and inhibitory effects of a given drug on the same effector organ. For example, epinephrine produces both a rise (vasoconstriction) and a fall (vasodilatation) in blood pressure, and perhaps the best explanation for this biphasic effect is to propose that epinephrine combines with one type of receptor to elicit excitatory response and a second type of receptor to elicit inhibitory response.

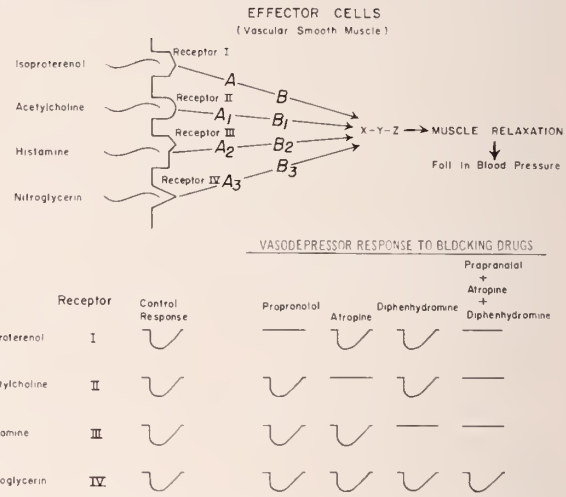
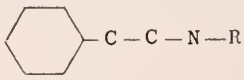


Fig. 1—Schematic representation of the receptor concept. Isoproterenol, acetylcholine, histamine, and nitroglycerin all produce relaxation of the vascular smooth muscle and thereby a fall in blood pressure. On the basis of selective inhibition by appropriate blocking agent, it may be easily differentiated that the site of action (receptors I, II, III and IV) of these drugs on the muscle cell must be different, although the final effect may be mediated through a common mechanism (steps x, y, z). Thus, propranolol inhibits the vasodepressor response to isoproterenol; atropine selectively blocks the effect of acetylcholine; the effect of histamine is antagonized by an antihistaminic drug, while vasodilator effect of nitroglycerin is unaffected by these blocking agents.

The receptors involved in the mediation of pharmacological effects of both endogenous and exogenous sympathomimetic amines are described as the *adrenergic receptors*. There are at present a large number of drugs which are derivatives of the basic structure:



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and are broadly described as adrenergic drugs, adrenergic amines, sympathomimetic amines, catecholamines etc. As early as 1906, Sir Henry Dale[2] described many of the stimulatory and inhibitory effects of epinephrine and norepinephrine and pointed out that only certain pharmacological effects of these agents such as increase in blood pressure, smooth muscle contraction, could be blocked by pretreatment with ergot alkaloids, one of the first adrenergic blocking drugs. However, the cardiac stimulant action of the catecholamines was unaffected by doses of ergot which completely reversed the pressor response. Although functionally both rise in blood pressure and increase in myocardial contractile force are excitatory responses, in terms of present day receptor concept, they are mediated through activation of different types of receptor. Since various pharmacological actions of sympathomimetic amines could not be described properly as mediated through activation of *excitatory* and *inhibitory* receptors, Ahlquist,[3] in 1948, used the term *alpha* and *beta* receptors to characterize these effects. This classification of adrenergic receptors is now widely accepted on the basis that the pharmacological actions of most sympathomimetic amines can be described in terms of responses elicited by stimulation of either *alpha* or *beta* receptors. At present, a number of sympathomimetic drugs are available which stimulate selectively either the *alpha* receptors, the *beta* receptors, or both types of receptors, and the physician can select a given agent for the desired clinical effects. For instance, if the physician wants to raise the blood pressure without concomitant stimulation of the myocardium, he should select a pure *alpha* receptor stimulant such as methoxamine (Vasoxyl), but when he desires an additional myocardial stimulation, he should prefer an agent which activates both *alpha* and *beta* receptors. The important pharmacological effects of sympathomimetic amines in terms of *alpha* and *beta* receptor stimulation are shown in Table 1. Some of the commonly used agents in clinical practice are also classified in terms of their receptor stimulation properties in this table.

The significance of a working knowledge of the receptor activation of sympathomimetic amines is also apparent in the selection of a bronchodilator agent in the treatment of asthma, since only a drug with *beta* receptor stimulant properties will be effective in this disorder. It would be ideal to increase further the selectivity of action of the catecholamines on a given organ beyond the realm of receptor classification, but so far this has not been possible in the case of adrenergic drugs. In other words, an agent which selectively produces vasoconstriction, vasodilatation, cardiac stimulation, bronchial relaxation or central nervous system stimulation without any of the other effects in therapeutic dose range may be more desirable from a therapeutic standpoint than a drug which has more than one effect, since this selectivity of action would minimize the side effects. For example, with such an agent, it may be possible to eliminate the cardiac stimulant effects (palpitation) commonly seen when isoproterenol, ephedrine or epinephrine is given to a patient with bronchial asthma. It must be pointed out, however, that some selectivity of action can be achieved by the route of administration of the drug, as is the case with topical application of phenylephrine or phenylpropanolamine as nasal decongestants.

Adrenergic Blocking Agents

The importance of receptor classification becomes even clearer when one considers the pharmacology of adrenergic blocking agents. Since the early observations of Dale on ergot alkaloids, a large number of drugs which block the vasopressor effect of norepinephrine and other catecholamines have been synthesized. However, it is now very well recognized that these blocking agents are *ineffective* against the vasodilating, bronchodilating, or myocardial stimulating effects of sympathomimetic amines. They are now classified as *alpha* adrenergic blocking agents, and some of the important members in this group include phenoxybenzamine (Dibenzyline), phentolamine (Regitine) and tolazoline (Priscoline). The most important clinical application of these drugs is in the diagnosis of pheochromocytoma, and during the surgical removal of the tumor so as to prevent the exaggerated rise in blood pressure. Based on our knowledge that hypertensive effect of catecholamines is mediated through activation of *alpha* receptors, it is easy to visualize that the *alpha* adrenergic blocking drugs would lower the blood pressure in pheochromocytoma. However, these drugs alone may not modify the tachycardia and cardiac arrhythmias associated with such a high concentration of circulating

TABLE 1—*Responses mediated through activation of . . .*

Organ	Alpha Receptors	Beta Receptors
Blood Vessels	Rise in Blood Pressure	Fall in Blood Pressure
Skeletal muscle	Vasoconstriction	Dilatation
Skin, mucosa	Vasoconstriction	Dilatation
Viscera	Constriction	Dilatation
Coronary	Constriction	Dilatation
Heart		
Rate	Decrease*	Increase
Contractile force		Increase
Arrhythmias		May be precipitated
Bronchial Smooth Muscle		Relaxation

Sympathomimetic Drug	Cardiovascular Actions				Bronchioles
	Blood Pressure	Heart Rate	Heart Force	Arrhythmias	
I. Predominantly alpha receptor stimulants					
1. Methoxamine (Vasoxyl)	Increase	Decrease*		Nil	
2. Phenylephrine (Neo-synephrine)	Increase	Decrease*		Nil	
II. Predominantly beta receptor stimulants					
1. Isoproterenol (Isuprel etc.)	Decrease	Increase	Increase	Yes†	Relaxation
2. Isoxsuprine (Vasodilan)	Decrease	Increase	Increase	Yes†	Relaxation
III. Stimulation of both alpha and beta receptors					
1. Epinephrine	Increase or Decrease	Increase or Decrease*	Increase	Yes	Relaxation
2. Norepinephrine	Increase‡	Increase or Decrease*	Increase	Yes	
3. Ephedrine	Increase‡	Increase or Decrease*	Increase	Yes	Relaxation
4. Metaraminol (Aramine)	Increase‡	Increase or Decrease*	Increase	Yes	

*Reflex bradycardia.
†Not usually seen.
‡Predominant effect is on alpha receptors.

catecholamines especially during the surgical manipulation of such tumors, and hence one must keep in mind that a simultaneous use of a *beta* adrenergic blocking agent would be invaluable in these patients.

On the basis of their action on the peripheral vasoconstrictor effects of catecholamines, many investigators have proposed that the *alpha* adrenergic blocking drugs should be useful in primary hypertension and peripheral vascular diseases. However, in clinical practice, the results have not been very successful in most of these diseases, and chronic use in many patients produced many undesirable side effects such as palpitation (tachycardia), postural hypotension, nasal stuffiness, and inhibition of ejaculation. Since better antihypertensive drugs are available in the market, *alpha* adrenergic blocking agents are now obsolete for the above disorders. However, a very favorable response is observed in patients with Raynaud's disease, in whom relatively small doses of phenoxybenzamine, tolazoline (Priscoline) or phentolamine (Regitine) have been observed to relieve vascular spasm resulting in an improved circulation and skin temperature. The use of phenoxybenzamine (Dibenzyline) has been suggested in recent years in the treatment of hemorrhagic, endotoxic, and cardiogenic shock, but its therapeutic effectiveness in such cases is not firmly established.

The choice of preparation of an *alpha* adrenergic blocking drug depends primarily on the desired duration of action. In the diagnosis of pheochromocytoma, a preparation with a very short duration of action should be selected. Thus, phentolamine (Regitine) has been widely used as an office procedure for this purpose. A fall in blood pressure of 35/25 mm Hg or more following intravenous injection of 5 mg phentolamine is considered to be a positive response. An agent with a long duration of action, such as phenoxybenzamine, would be more useful in the preoperative management of pheochromocytoma or for the prolonged treatment of cases not amenable to surgery. In these patients, the drug is given orally in doses ranging from 10 mg to 200 mg per day. During the surgical removal of the tumor, both phenoxybenzamine (1 mg/kg given intravenously 36 and 12 hours prior to the operation) and phentolamine (2.5 or 5 mg I.V. or by continuous drip) have been very successful to prevent the acute hypertensive crisis.

The *beta* adrenergic blocking agent is a relatively new group of drugs, and most of the agents in this series are synthesized by a slight chemical modification of isoproterenol structure. Although many compounds have been synthesized in this series, only propranolol (Inderal) is available as a prescription drug in this country.

The *beta* adrenergic blocking agents have several important pharmacological effects, most of which are based on their ability to inhibit the actions of endogenous catecholamines on the *beta* adrenergic receptors. For instance, the heart rate and myocardial contractility is regulated by the rhythmic release of norepinephrine from the cardiac sympathetic nerves, and the blockade of the effects of such endogenously released amine on the cardiac *beta* receptors may account for the decrease in heart rate and contractile force commonly seen following the administration of propranolol and similar drugs. Clinically, these drugs should be very useful in conditions which may be either precipitated or worsened by an excessive sympathetic drive to the heart, and include cardiac arrhythmias, angina pectoris, pheochromocytoma, and idiopathic hypertrophic aortic stenosis.

The antiarrhythmic activity of *beta* adrenergic blocking agents is now well established in both experimental animals and in man. These drugs are most effective in preventing or abolishing those arrhythmias which are precipitated by catecholamines with or without the presence of a "sensitizing" agent such as halothane or cyclopropane. Suppression of such adrenergically induced arrhythmias is a reflection of the *beta* receptor blockade produced by these drugs. Some of the *beta* adrenergic blocking agents, such as propranolol can also abolish ventricular ectopic beats or ventricular tachycardia resulting from digitalis overdosage. However, suppression of digitalis induced cardiac arrhythmia is not due to a *beta* receptor blockade, but due to a nonspecific or quinidine-like anti-arrhythmic effect. Propranolol has also been reported to decrease the heart rate (ventricular rate) in patients of atrial flutter and fibrillation, although a restoration of normal sinus rhythm was not seen in most patients.

Beta adrenergic blocking agents have been shown in several clinical trials to be very effective in the management of angina pectoris, and both subjective and objective improvements have been recorded. Since these agents produce a coronary vasoconstriction by inhibiting the *beta* receptor mediated relaxation of vascular smooth muscle, the beneficial effect in patients with angina pectoris would seem to be due to a reduction in the myocardial work and oxygen requirements. This, of course, will be expected on the basis of their specific *beta* adrenergic blocking action, since one of the deleterious effects of catecholamines is to precipitate anginal attack in susceptible patients by increasing the myocardial oxygen consumption. Also, the increase in heart rate, cardiac output and systemic blood pressure in response to exercise does not increase as much after propranolol as during the control period.

Propranolol is available for both oral (10 and 40 mg tablets) or intravenous (1 mg/ml ampule) administration. In most patients, the drug should be given orally, and the dose should be adjusted individually. The usual daily dose is 10 to 30 mg three or four times a day before meals. In cases of severe life threatening arrhythmias, the patient should be hospitalized and propranolol may be used intravenously. In such cases, with continuous electrocardiographic monitoring, the drug may be given by I.V. drip, but the dose must not exceed 1 mg/minute. Propranolol should be stopped when the arrhythmias are completely suppressed or a toxic effect of the drug on the rhythm or A–V conduction becomes apparent. The drug may also be used intravenously during surgical removal of the pheochromocytoma tumor, but the same precautions should be observed.

However, propranolol should be used very cautiously in the management of cardiac arrhythmias or angina pectoris. It has already been pointed out that a reduction in heart rate and myocardial contractile force due to a decrease of physiological activity of cardiac sympathetic nerves would decrease the cardiac output, and hence in many borderline cases, chronic administration of propranolol may precipitate congestive heart failure. It is therefore imperative that the drug should be given in small daily amounts initially and the dose should be gradually increased until the desired effect is obtained or until side effects are seen. The physician should be extremely careful and should monitor the cardiac activity constantly if the drug is given by the intravenous route for the treatment of severe ventricular arrhythmias.

Other side effects during a long-term administration of propranolol may include lightheadedness, tiredness, drowsiness, nausea, mild diarrhea, and skin rashes. These side effects could not be predicted easily on

the basis of *beta* receptor blockade. One of the major side effects in many patients is an increase in airway resistance, which may actually precipitate an acute attack of asthma in some susceptible cases. It has been pointed out earlier that relaxation of bronchial smooth muscle is mediated through the activation of the *beta* adrenergic receptors, and therefore a blockade of such an effect may be responsible for a decrease in the size of the bronchioles. It also follows from this discussion that propranolol will be contraindicated in the presence of bronchial asthma. The bronchial relaxant effect of epinephrine, ephedrine, or isoproterenol will be minimal following the administration of *beta* adrenergic blocking agents. These drugs should be used very cautiously in patients receiving reserpine, guanethidine, or methyldopa, since an added depletion of catecholamines may produce an excessive depression of the sympathetic activity.

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Therapeutic Dilemmas

No. 8 of a Series

Editor:

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COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

LEGAL AND MORAL PROBLEMS OF EMERGENCY CARE

Moderator: FRANCIS F. ROSENBAUM, M.D.

Participants: FRANCIS F. ROSENBAUM, M.D.
ROBERT SANTILLI, M.D.
SIDNEY SHINDELL, M.D.

Dr. Francis F. Rosenbaum: Today we are departing from usual practice in these Tuesday morning conferences in that we have set up for discussion an imaginary case rather than an actual one. This has been done in order to provide our guest, Dr. Sidney Shindell, with opportunity to dwell upon the several points he would like to make in alerting us to the obligations and safeguards of the physician in the treatment of an emergency case. Doctor Shindell, who has the unique distinction of being both a physician and a lawyer, has recently become Chairman of the Division of Preventive Medicine at Marquette School of Medicine and is attending physician at the Milwaukee County General Hospital. He has come to Milwaukee after a distinguished career in like roles at the University of Pittsburgh, and we are highly honored in having him with us today. Doctor Santilli will present the "case."

Dr. Robert Santilli (Resident in Medicine): A 19-year-old white man with a history of manic-depressive psychosis was brought into the Emergency Department of the hospital via private ambulance after a friend had found him stuporous at home. Allegedly he had ingested an undetermined amount of secobarbital (Seconal) three to six hours prior to reaching the hospital. His parents could not be located.

The patient, who was 6′2″ tall and weighed 220 lb, became belligerent upon admission and refused gastric lavage and confinement for treatment. The Emergency Department nurse wanted to notify the police regarding the attempted suicide, but the patient's psychiatrist, who had been reached by phone, advised against this but requested that the lavage and necessary confinement be undertaken. The lavage was then carried out with the aid of four orderlies, one of whom was slightly injured during the procedure.

Physical examination revealed a well-developed young man, initially drowsy with slurred speech and confused mentation.

Facies were florid. Blood pressure was 120/70 mm Hg; pulse 68 and regular before the period of violence. The hemogram, urinalysis and liver panel were normal. The blood serum contained 0.6 mg/100 ml of barbiturate.

Dr. Rosenbaum: Doctor Shindell, you may use this case in any way you desire to illustrate the points you wish to bring to our attention.

Dr. Sidney Shindell: The most important questions posed by this case are: (a) what is the nature of the relationship between patient and physician; (b) when does it come into being; (c) what is especially involved when a minor enters the hospital for emergency care; (d) what are the things particularly at issue in emergency vs. nonemergency care; (e) what sort of force, if any, may be employed in providing emergency treatment; (f) what kind of consent is a minor able to give; (g) who can act for him if the parents are not available; (h) what is the hospital's liability to an employee who is injured during the rendering of emergency care?

The basic relationship between patient and physician is looked upon by the law as a contractual one, just like any other commercial contract; and the implication of this is that doctor and patient are equal parties. I emphasize this since we as physicians are inclined to think of the physician as the dominant person in the relationship, with the patient in a relatively passive or subservient role. This is because it is necessary at times for us to take over from the patient, make decisions for him, etc., but actually from the legal point of view there must be mutual patient/physician consent to a course of action.

All contractual relationships start when an offer by one party is accepted by another. When a patient enters a doctor's waiting room, no offer has yet been made by him, or accepted by the doctor, to enter into a contract. However, when you begin taking a history from the patient he is in effect making an offer to you to engage your services. But you need not accept his offer and may still decline to take his case if you wish; i.e., you have not entered into a contract with him for continuing care until you have decided that you will accept him as a patient. For example, if you feel that the problem presented is not within your area of competence, you may recommend him to go elsewhere, or even make a definite referral, and have still not entered a contract to do anything beyond evaluating his problem. Once you have decided to accept the individual as a patient, however, you still have not entered into a contract with him, which will be legally recognized as such, unless both parties are competent to make a contract and have a lawful object in mind. Therefore, if you have undertaken to perform some sort of medical service that is considered unlawful, such as supplying a known addict with drugs or performing an illegal abortion, no contract has come into being.

As to the matter of the competence of both parties to the contract, the patient must be mentally competent and of age and you must be licensed to practice medicine. Whether you are considered competent by your confreres to perform certain highly specialized services is a separate issue. Contracts also must be in a specific form and be accompanied by "consideration." Unlike many contracts, which are required to be in writing, that between patient and physician, although only oral, is recognized in the law as being valid. The matter of "consideration" means that an item of value passes from one individual to the other. Legally, the service you render is an item of value; the money that the patient is to pay you is the reciprocal item of value.

This, then, is the normal situation where an offer to perform a lawful object has been both made and accepted by competent parties and is accompanied by adequate "consideration." But what is the relationship when the patient is unconscious though requiring emergency care? Is he able to make an offer and hence enter into the contract? Well, the law presumes that a contract is entered into because the condition of the patient is an implied offer to you to render service. This is one of the reasons that people have been so upset about stopping to render service on the highway; presumably the injured individual is implicitly making an offer to you and if you render service you have accepted his offer and entered a contract. And once such a contract has been entered it may not be terminated by the doctor unless the patient has been afforded reasonable opportunity to obtain other medical care. Of course a patient injured on the highway has little or no opportunity to obtain such other medical care, and therefore a continuing doctor/patient relationship has presumably come into being,

and the doctor cannot abandon his patient short of definitive medical care and until opportunity for other competent medical management has been provided. I say "presumably," because to my knowledge no court has actually held this to be the law. But such a holding would be consistent with basic legal principles. In order to clarify the problem, however, in Wisconsin (among 32 other states) the Good Samaritan Act has stated clearly that a doctor/patient relationship does not arise under these circumstances and the doctor may render first-aid without incurring the obligation of supplying further definitive medical care.

Once a true doctor/patient relationship has been established, the law requires essentially only two things of the doctor: one, that he does not abandon his patient; and two, that he provides an appropriate standard of care. Note carefully that this "appropriate standard of care" means, in the law, that he is to be as careful in the management of his patient as other physicians in like circumstances with like training are expected to be. It does not require infallibility, only conscientiousness. In addition to the standard of care we bring to our patient, the law also imposes upon us an obligation to every individual in our society to keep him from harm if we can. We owe everyone the obligation not to inflict positive harm upon him; and harm can mean either physical hurt or apprehension of same. We can only cause pain or discomfort if the recipient is willing to relinquish his right to remain unharmed. Consequently, whenever we do anything with or for a patient that is likely to involve the risk of pain or threat to well being, we are obligated to make the patient aware of what it is we wish to do and the risk involved, stating the matter in such terms that he can intelligently decide whether he wishes to permit the thing to be done. Failure to do so constitutes an assault for which we might be held liable.

Now let us look at our imaginary patient. He is 19 years old. Since he is not a legally competent party to enter into a contract, we must negotiate with an adult on his behalf. Further, he may not validly give consent to our causing discomfort until he is 21 years old. Hence normally in order to deal with a minor one must reach an adult who will act in his behalf. However, in emergency situations, in which a valid attempt to reach such an adult has been made (as in our case), emergency therapy may be given. Once the emergency is over, authorization for continuing therapy must again be given by an adult in his behalf; and if a family member is not available, one may seek authorization of the Juvenile Court.

The problem of gastric lavage in our case did not carry great risk and there is no reason to hesitate about proceeding with treatment, but injuries that might involve emergency amputation or other mutilating procedures can be very serious matters indeed unless adequate consent is obtained.

Now in our case again, because no contract was entered into since the patient was a minor, the law creates something called quasi-contract. This differs from a true contract in a minor particular in that you or the hospital are entitled to receive a reasonable amount of compensation for what you did, that is, a "customary and reasonable fee" which may not be your normal one. If you have a highly specialized practice and are accustomed to an increased fee on the basis of your preeminence in your field and render necessary care to a minor not authorized by an adult in his behalf, you may not receive this increased fee but only the normal fee for such services in your community. Of course we all recognize that the first obligation is to take care of the patient, and I merely mention this matter of the fee to acquaint you with the state of the law in this specific instance.

Now the question of reporting the attempted suicide to the police. Suicide is a common-law crime but in our society attempted suicide is not; therefore, the attempt need not be reported. Actually to report an attempted suicide might be a breach in your obligation to your patient to maintain confidentiality of medical information. The law on suicide, while an apparent absurdity, very interestingly stems from the time of William the Conqueror in the England of the 1060s. The people who lived in William's England were under obligation to supply him with an army whenever he needed it. And therefore whenever any one of these people killed himself, William was deprived of a potential soldier. So he established suicide as a crime with the penalty of sacrifice of all the suicide's holdings to the state. We no longer have the latter stipulation, but the suicide itself is still a crime in many states. An *attempted* suicide today is only a crime if

committed under circumstances involving a disturbance of the peace; such an individual is charged only with disturbance of the peace, not with attempted suicide. Our patient therefore committed no crime and was not reportable. Sometimes, however, it is worthwhile reporting such an incident as a step toward trying to get the patient under psychiatric therapy, but here he was already under psychiatric care.

From the legal point of view the actual treatment given in this case was fine. You may use whatever is necessary to provide emergency therapy; and in this instance you did so with the aid of four orderlies. It is possible, under certain circumstances, to commit assault upon a patient in order to accomplish this. I do not mean technical but actual assault. Witness the recent case, in one of the Washington hospitals, of a house officer who was examining the mouth of a small child who clamped down on his finger and refused to open his jaws although he was severely injuring the doctor's finger. The doctor was obliged to slap the child's face to make him let go. The mother, outraged at this, sued the doctor for assault, but the courts held that he was perfectly justified in what he had done. The rule is that one can commit an assault to protect oneself or other persons; i.e., one can repel force with force provided no more is exercised than absolutely necessary.

A Physician: What would you say regarding the orderly who was injured while subduing this imaginary patient of ours?

Dr. Shindell: If the hospital is covered by Workmen's Compensation, as I suspect it is, then his benefits are limited to this compensation and not to a suit against the hospital. Under Wisconsin law, a person entitled to Workmen's Compensation does not have an independent right to sue his employer.

A Physician: What is the situation regarding a physician who has fewer than three employees in his office and is therefore unlikely to be carrying Workmen's Compensation insurance?

Dr. Shindell: There is involved here the question of whether the employee does not assume a certain risk in entering into such employment, knowing that situations could arise that are potentially annoying or dangerous. The comparison is perhaps valid with a person who sits in the front row at a hockey match when it is known that the puck goes flying all over the place in such a match. The stadium cannot be sued for damages under such circumstances if the man is hit in the face, because in sitting in the first row he has assumed a certain risk. Actually a physician, as well as an employee of a physician, assumes noncompensable risks upon occasion; for example, when he sees a patient with infectious disease or goes down into a collapsed well to give aid to or help in the extrication of an individual entrapped there.

A Physician: A question about the gastric lavage. Was this obligatory?

Dr. Shindell: This is a matter of medical judgment. There is no rule of law that tells you how you are to treat your patient. You are only to bring to your relationship with him that degree of skill and conscientiousness that is exercised by other physicians in the community under like circumstances. If in this community such a patient would be lavaged under these circumstances, then you would run some legal risk if you did not lavage him. But this is a matter of medical judgment. If you have exercised good judgment, and it is the judgment your confreres would have exercised under similar circumstances, there is no liability on your part even if there is an untoward effect. The mere fact of an untoward result does not imply liability on the part of the doctor. There is only one thing really that may make a physician liable to judgment. If it can be shown that he was derelict in his duty to provide the patient with a high standard of care, and that damage was done to the patient as a result of this dereliction, he is then in a position of liability. Otherwise not. Of course he may be sued; anybody may be sued for anything. But such a suit, provided the foregoing stipulations are not provable, is not likely to be won. For example, suppose our patient had come in pulseless and died in spite of the use of all the indicated measures of resuscitation. You could not be successfully sued for not having resorted to lavage, since first things must be done first, and attempt to reestablish a pulse took precedence over everything else.

A Physician: Suppose I am called at my home in the middle of the night by one of the house staff for advice regarding a child who has allegedly swallowed some unknown kind of poison. If I advise lavage and there is an untoward result, the child aspirates stomach

contents or something of that sort, am I liable?

Dr. Shindell: What you are really asking is whether being a doctor requires the exercise of judgment. And the answer is yes it does. And any time you exercise judgment may someone question it? And the answer is yes, someone may. I can only say that if the judgment you have exercised is the same as is likely to have been exercised by a substantial number—not necessarily the majority—of your confreres, then you have exercised appropriate judgment. I firmly believe that what is good medicine is also good law. Nobody of course can keep you from being sued, but a suit would be hard to win if the circumstances were as I have stated them. The public tends to be reasonable, but what it definitely does not want is for a man to say, "I did what I did because I am the doctor and I don't have to answer to anybody."

A Physician: What is the position in Wisconsin regarding the concept of *res ipsa loquitur;* I understand that in California the principle is frequently invoked?

Dr. Shindell: You are correct in the California attitude regarding *res ipsa loquitur,* the statement that "the facts speak for themselves." In that state, because of the alleged inability to get a doctor to testify against a doctor, they have assumed that when the circumstances surrounding a situation in which the doctor is being accused of negligence are such as do not ordinarily occur unless there has been negligence, then negligence is presumed to be present, and the physician is required to rebut the presumption. This is, of course, a quite unreasonable and frightening attitude because it assumes the doctor to be "guilty" and requires him to prove his "innocence." Other states do not presume such guilt except in the most flagrant of cases. Wisconsin attempts to deal with the problem of availability of medical testimony by permitting evidence of alleged negligence on the part of the physician to be obtained from various sources; for example, from textbooks if certified to be authoritative. The doctor has the opportunity, of course, to refute the written word of recognized authorities with that of other authorities or by testimony of his confreres.

A Physician: If a drug has been approved by the FDA and the doctor prescribes it according to the package stuffer, and it is later shown that the drug causes some damage and it is withdrawn from the market—as in the case of MER 29—what is the doctor's liability if his patient did develop deleterious reaction in question, let us say cataracts as in the case of MER 29?

Dr. Shindell: The doctor might have been liable only if there were reports of the drug's adverse reactions which he ignored. Otherwise he was exercising the best degree of conscientiousness that could have been expected of him. However, if he had noticed something beginning to happen to his patient and did not investigate the literature to see whether such happenings were being reported by others, he could perhaps be considered liable. But the law requires him only to be familiar with the literature that he may be expected ordinarily to have read. For example, if there had been a lead article in the *J.A.M.A.* three or four months previously dealing with this situation, he might be expected to know about it, whether he actually gets the Journal himself. His confreres do and he can be expected to be aware of this information and cannot plead ignorance. But if the article appeared in the student's medical journal of the Thailand Medical School, he would not be held liable if he did not see it.

Dr. Rosenbaum (summarizing): This morning we have had the privilege of an exposition by Doctor Shindell of our obligations in the treatment of an emergency case in circumstances that may arise at any time in the practice of any physician. The conditions under which he may be held delinquent in the discharge of his duty have been clearly stated as well as the measures by which he may be protected against actions that might be brought against him.

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the WISCONSIN MEDICAL JOURNAL
Published Monthly

JUNE 1968

Vol. 67 No. 6

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

The Commodity and the Cost

HOW MUCH SHOULD a doctor earn?

Is he entitled to a fair return for his services? Or is he in some kind of special category that demands he receive proportionately less for his work than other professional people?

While few practicing physicians are suffering economic hardships nowadays, the ones that have gouged their way to remarkable affluence are equally few. It is an incontestable fact that most are enjoying a prosperity commensurate with their economic class and the traditional status of their profession vis-a-vis all other working, business, and professional income earners.

In recent months, however, doctors have been subjected to frequent blasts from various quarters for allegedly taking advantage of the current expansion of tax-supported medical care programs to feather their economic nests. Some ill-advised, professionally prominent colleagues have added their voices to the baying of the critics and have contributed to a public impression that doctors are somehow getting unduly wealthy on the distress of their patients.

Except in the instance of a few unscrupulous get-rich-quick operators who would probably assume the same posture in any circumstances, the criticism is grossly misdirected.

The figures most often quoted by the critics indicate that doctors' fees have risen at the rate of 3% per year in the period from 1960 to 1965. In 1966, the first year of Medicare, doctors' fees rose nearly 8%. Therefore, conclude the critics, the medical profession saw an opportunity for vast profit and took advantage of it. What is left unsaid is that in the period from 1940 to 1955 doctors' fees rose 65% while the cost of living went up 91%, and they finally caught up only in 1966. The increase of 7.8% that occurred in 1966 probably resulted from the fact that a larger than usual number of doctors adjusted their fee schedule upward at the same time because they had been lax in increasing their fees in prior years in the face of rising costs. The uncertainties attendant on the new governmental program undoubtedly compelled most doctors to take a long-overdue look at the economic aspects of their practices.

What they saw when they finally took a good look at their fee schedules in the light of the current economic facts of life

convinced many doctors that their lack of attention to business detail was costing them dearly. The day had long since gone when a lone practitioner could do with a single young girl whom he could train in a few weeks to take care of the simple chores around the office that he didn't want to handle himself. He now needs mature, well-trained technicians, business machine operators, and assistants to perform the vastly more sophisticated tasks involved in a medical office. These people do not work for nothing; indeed many doctors find that they now have a payroll in excess of what their entire overhead was only a few years ago. With the advent of Medicare and Medicaid and with the ever-increasing number of patients with insurance coverage, the amount of non-medical paperwork required of the doctor has proliferated to a staggering degree. Merely to keep abreast of non-medical administrative detail, the doctor today must invest in expensive dictating equipment, copiers, electric typewriters, management services, and other items that do not relate directly to medical care.

Additionally, out of the patients' just demand for more comfortable treatment has come the need for larger, better equipped and more comfortable offices. More aesthetically acceptable, air-conditioned, and better furnished quarters not only have made the patient feel more at ease but also have contributed to the doctor's efficiency.

And finally, the explosion of medical knowledge has forced most doctors to spend heavily for modern, complex instrumentation and diagnostic equipment, some of it costing thousands of dollars.

With such tremendously increased overhead expenses, a doctor must continue to earn constantly to keep abreast of them. But a doctor can no longer coast along with what he learned in medical school—he must be concerned with his own continuing education: books, journals, seminars, postgraduate

JAMES O. KELLEY, EXECUTIVE SECRETARY, CELEBRATES 30TH ANNIVERSARY WITH MILWAUKEE MEDICAL SOCIETY

April 20, marked 30 years of continual progress by The Medical Society of Milwaukee County with Executive Secretary and General Manager James O. Kelley. He has also served in the same capacity for the Society's Surgical Care, Blue Shield Plan for the past 25 years.

In addition to his position at the Medical Society, Mr. Kelley is also a Marquette School of Medicine faculty member. He lectures in Medical Ethics, Medical Economics and Medical Jurisprudence, as well as Social and Community Medicine.

Mr. Kelley is also currently serving as a member of the following Boards of Directors: American Cancer Society, Milwaukee Blood Center, and the Marine National Bank.

He has also been affiliated with numerous local, state and national organizations including, the Wisconsin Public Health Association, American Public Health Association, American Association for Medical Society Executives, Milwaukee Better Business Bureau, Milwaukee Association of Commerce, and the Milwaukee County Mental Health Association.

Numerous Blue Shield activities have been credited to Mr. Kelley. He served on the Board of Directors and as treasurer of the National Association of Blue Shield Plans. Since 1951, he has been a director of Medical Indemnity of America, Inc., a stock insurance company. He is a former director of Health Services Insurance Company, the national marketing organization for Blue Cross Plans. From 1951 to 1962 he was a member of the Executive Committee, National Association of Blue Shield Plans.

Other affiliations include the Marquette University Alumni Association, Association of American Medical Colleges, National Foundation, Navy League of U.S., Milwaukee Press Club, and the University of Wisconsin Alumni Association.

Mr. Kelley was also the founder and member of the U.S. Committee, World Medical Association.

Originally, Mr. Kelley was born and grew up in Merrill, Wisconsin. His parents are the late Dr. and Mrs. Francis H. Kelley.

—Reprinted from MILWAUKEE MEDICAL SOCIETY TIMES, May 1968

courses, and conventions. The financial penalty for such self-improvement is fantastic, for in addition to the actual cost of taking courses or going to conventions he must support the fixed overhead expense which is part of his practice, at the very time that he is totally deprived of income because he is not seeing patients.

The high cost of practicing medicine is seldom if ever discussed in the sensational blasts leveled at doctors. It's much simpler to portray the medical profession as a bunch of bad guys rather than let the hard realities of economic life disturb the prejudices of those who think in superficialities. And it is unfortunate that there is no dearth of demagogues who will pander to popular misconceptions for the sake of a quick, though transient, popularity.

Since nobody seems ready to rush to the defense of the medical profession, doctors will have to stand up for themselves. The tiny fraction of medical practitioners who have identified themselves as fee gougers, and who have taken advantage of Medicare and Medicaid to escalate their fees unconscionably, are likely to be exposed by the carriers, and are being dealt with by their colleagues in the profession. County societies should, of course, maintain and even intensify their vigilance in this respect. But doctors should be prepared to stand in their own defense individually. For their own sakes they cannot remain mute in the face of some of the ridiculous charges of profiteering that are being made. They should know, for instance, that the hospital is responsible for the largest percentage of increase in the cost of health care. Every doctor should know precisely how much his own fees have gone up over what period of years, and he should be ready to explain why he couldn't continue to practice in 1968 charging 1965 prices.

And if public spirited physicians do undertake to speak out against the rare medical profiteer, it is to be hoped that they will be responsible enough to focus their charges to avoid smearing the entire profession with glib statements either not true, partially true, true with qualifications, or subject to misinterpretation by elements of the public who are not completely informed.—D.N.G.

Carl N. Neupert, M.D.—*A Dedicated Physician Leader in Public Health*

On a brilliant fall day in 1942, Cornelius A. Harper, M.D., then State Health Officer, asked for an appointment at my office.

It was, of course, promptly provided, and Doctor Harper brought with him Doctor Neupert and told me that he would be his successor as State Health Officer.

Carl was a loyal member of the medical profession and his teamwork with the State Medical Society in the ensuing years was outstanding, readily available, always considerate, and from a physician who had the temperament and the courage to stand by his decisions. No one who worked professionally with Carl could, I think, help but become his friend in a personal as well as an official sense. And that we were—Carl and Melba, his very loyal and devoted wife, and Charlie and Marion Crownhart.

When Carl received the Council Award in May of 1965, it was noted of him that he "has been a valued participant and leader in the affairs of organized medicine as well as being an effective and dynamic spokesman for public health. He has firmly believed that society has not completely fulfilled its obligations to our people when it has given them decent wages, incomes, the highest possible standards of living, and security in their jobs and homes, but has recognized that our people also want to be strong, vigorous, and healthy in mind and body.

"For your accomplishments in the many advancements in the area of public health; for your leadership to the State Board of Health; for your dedication to Wisconsin and its citizens; for your devotion to the Hippocratic principles in every respect of your work, and for your long and faithful service in the interest of your chosen profession and of the public's health and welfare: We your fellow members give you this Seal of our Society as a token of your achievements and of our deepest respect for your contributions to medicine, and to the people it serves."

This was his accolade in life . . . it is our tribute now in his passing on.—C.H.C.

THE MEDICAL STUDENT FORUM

Devoted to the expressions of the medical students at the University of Wisconsin and Marquette medical schools through association with the Student American Medical Association. A feature originated by the State Medical Society of Wisconsin to stimulate closer relationships with the physicians of tomorrow. This space is offered monthly to both schools on an alternating basis, with copy deadline the first of the month preceding the month of publication. Statements and opinions contained herein are those of the students.

JUNE 1968

THE 1968 Student American Medical Association convention was held in Detroit April 24–27. Marquette School of Medicine was represented by Barry Maxfield, John E. Inman, Bruce Buchanan, and C. Robert Stanhope. Total registration at the convention included more than 1,400 delegates, WASAMA members, exhibitors, and visitors.

Various speakers at the different sessions and luncheons included George E. Burket, president of the American Academy of General Practice; Milford O. Rouse, president of the American Medical Association; and William H. Stewart, Surgeon General of the United States.

SAMA NATIONAL MEETING

Several symposia were held. "The Care and Feeding of Hippies" gave some of us an insight into the lives of the "beautiful people." In "The Physician's Life" we were told that the addiction rate among physicians is 10 times that of the normal population and that the suicide rate is double that of the average population. We were also given some interesting insight into "The M.D. as a Family Man." Group practice was also discussed in one of the symposiums.

A major portion of the time was spent discussing and voting on the record 76 resolutions submitted for consideration. Four reference committees heard discussion from people for and against the various resolutions, then combined and/or rewrote the similar resolutions. Their recommendations were then presented to the House of Delegates where more changes were often made before the final vote. Much of this work lasted far into the night with one session lasting until 5 A.M.

A summary of the major resolutions passed follows:

MAJOR RESOLUTIONS

1. SAMA should oppose legislation to extend sentences for the use of "dangerous drugs," and further that narcotics and marijuana are a medical problem as well as a criminal problem.

2. SAMA should support the initiation of a federal loan and fellowship program for all health students.

3. There was much discussion concerning the NEW PHYSICIAN and its layout. In the next year we should see drastic changes in this journal with less "scientific articles" and more articles concerning SAMA activities.

4. Renaming SAMA. A resolution to rename SAMA to American Association of Medical Students **was defeated.**

5. AMA Support. A resolution to support the AMA in all of its objectives and "in its fight against socialism" was not considered because it was felt that it had not been submitted in good faith.

6. Medicine and Osteopathy. There should be closer association between D.O.s and M.D.s with the sharing of postgraduate medical education and hospital privileges.

7. Community Health. Authorized establishment of a standing committee for community health to arrive at guidelines for SAMA activities in health care for the poor. At the present time a pilot program is being conducted by the Kansas City Chapter of SAMA with the aid of a $39,000 grant from the AMA.

8. Vietnam War. A resolution declaring that the Vietnam War "is unjustifiable both ethically and practically" and that the U. S. should de-escalate and negotiate an end to the War was presented. This issue was debated at quite long lengths before it was finally felt that the delegates did not have an adequate polling of their members' (back home) feelings to vote in a representative manner.

VIETNAM ISSUE TABLED

9. Externships. SAMA to encourage and support the continuation of externships. Note that the Joint Commission on Accreditation has recently been requiring the termination of all externship programs as a prerequisite to a hospital's accreditation.

10. Membership Solicitation. Local SAMA chapters should not pressure the incoming freshman classes into SAMA membership, but instead emphasize what SAMA has to offer.

The $39,000 grant from the AMA to help finance the student-to-people pilot project for communicating health information to residents of lower income indigent neighborhoods was a big boost to SAMA. The pilot project will be conducted in Kansas City where it has already been tested successfully on a limited basis for the past few months. SAMA will administer the project and the Kansas City chapter of SAMA will spearhead the effort in cooperation with other local organizations in that city.

This project was designed to utilize students from freshmen in high school up to graduate medical students to personally contact and work with residents of indigent areas and inform them of existing medical facilities available to them. According to SAMA president, David Kindig, who made the announcement of the grant at the meeting, work already being accomplished has proven that existing medical facilities can be more than adequate to answer the needs of the indigent. The pilot project will provide a working pattern for a person-to-person program for communicating the need of the neighborhoods in relation to the availability of existing medical services. The Kansas City project will provide answers for the expansion of the effort nationally, and results will be evaluated at the 1969 SAMA meeting in Chicago.

SAMA TO HELP INDIGENT

There were other viewpoints expressed at the meeting, including those of Dr. Quentin Young, chairman of the Medical Committee for Human Rights (MCHR), who challenged the delegates to the SAMA meeting to resist "being consumed by a parent organization that has no program for rectifying the health care problems of this nation's indigent people." Speaking before a hastily-called midnight meeting of delegates and paid guests, Doctor Young charged the AMA with being responsible for the crises he sees the nation facing today. He admitted to sharing AMA fears about nationalism. Calling the AMA "intrinsically undemocratic," Doctor Young called for: massive expansion of health techniques and specialties; more mobility of personnel; expansion of group practice; patient participation in health care areas; special incentives for serving in communities; increases in technology; and a multidisciplined, more affirmative, more localized medical organization.

The new president of SAMA–Marquette is John E. Inman (junior) who succeeds Bruce Buchanan (senior)
—JOHN E. INMAN, President, SAMA–Marquette.

WISCONSIN MEDICAL JOURNAL
VOL. 67, NO. 6 JUNE 1968

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

House of Delegates Adopts 3-Part Program for Blood Testing of Drinking Drivers

A three-pronged approach to the physician's role in testing the drinking driver was approved by the House of Delegates of the State Medical Society in Milwaukee, May 14.

The delegates:

1. Approved physician guidelines for highway accident blood alcohol testing. The guidelines are reprinted in full on pages 312 and 313 in this issue.
2. Reaffirmed support for legislation establishing implied consent for the performance of chemical tests on persons arrested for driving while under the influence of intoxicants.
3. Urged legislation providing "appropriate immunity" to a physician who uses chemical tests for intoxication at the request or direction of a law enforcement officer.

The society called upon the State Legislature to enact these laws in its 1969 session.

Representatives of the State Medical Society have worked with the Governor's Office and the Attorney General's Office in the development of the guidelines, and copies have been provided to each.

In a recent letter to the society, Governor Warren P. Knowles expressed concern that "over 70 per cent of the drivers killed during the first three months of 1968 on Wisconsin highways had been drinking."

He pointed out that efforts were being made to expand the availability of breath testing facilities, but that in some instances "breath testing is not feasible." When blood or urine testing is necessary, "the cooperation of the physician and other medical personnel becomes essential," the governor said.

"I would appreciate the cooperation of the State Medical Society in encouraging physicians to participate in the chemical testing program," the governor concluded. "Their assistance would be very helpful and beneficial to the people of Wisconsin."

DR. E. J. NORDBY NEW COUNCIL CHAIRMAN

The new chairman of the Society's Council, E. J. Nordby, M.D. (L), Madison, is shown with his predecessor, James C. Fox, M.D. of La Crosse. Doctor Nordby is a graduate of the University of Wisconsin Medical School and a specialist in orthopedic surgery. A former Speaker of the House of Delegates, he has been a member of the Council since 1964. Doctor Fox has been active in Medical Society affairs for nearly 25 years. He was first elected to the Council in 1947 and became its chairman in 1959.

Press for Med School Expansion

State funds to support the continued operation of Marquette School of Medicine were urged by the SMS House of Delegates.

In addition, the House urged the state to approve the recommendations of the Governor's task force on medical education which calls for expansion of both the University of Wisconsin and Marquette medical schools to admission enrollments of 160, plus immediate planning for a third medical school in Milwaukee.

Earlier the La Crosse County Medical Society had introduced a resolution urging the state to acquire Marquette Medical School and integrate it with the University of Wisconsin at Milwaukee as one of the divisions.

Urge Training of More General MDs

General practice received a boost from the House of Delegates with an appeal for greater emphasis on family medicine in the state's medical schools.

A Richland County Medical Society resolution calling attention to the acute shortage of general practitioners had wide appeal among the delegates. It blamed the shortage primarily "to the direction taken by teaching institutions in general" and urged Wisconsin's medical schools to lean to "a more general field of medical teaching than is now obtained with the emphasis on specialty."

The final action of the House, after extensive testimony at the Reference Committee by practicing physicians and medical school leadership, urged the University of Wisconsin and Marquette medical schools to implement their plans for divisions of comprehensive medical care. They were urged to do so in consultation with the Wisconsin Academy of General Practice and the Section on General Practice of the State Medical Society.

In addition, the House urged reexamination of the preceptorship programs to include the use of more practicing general practitioners, singly or in groups.

SEEK RULING ON STERILIZATION

The House of Delegates appealed to the state's Attorney General to issue a long-delayed opinion on the legality of non-therapeutic sterilization.

The State Board of Medical Examiners first asked for his opinion in 1966 and again in 1967, but there has been no reply.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others.

Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1968 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

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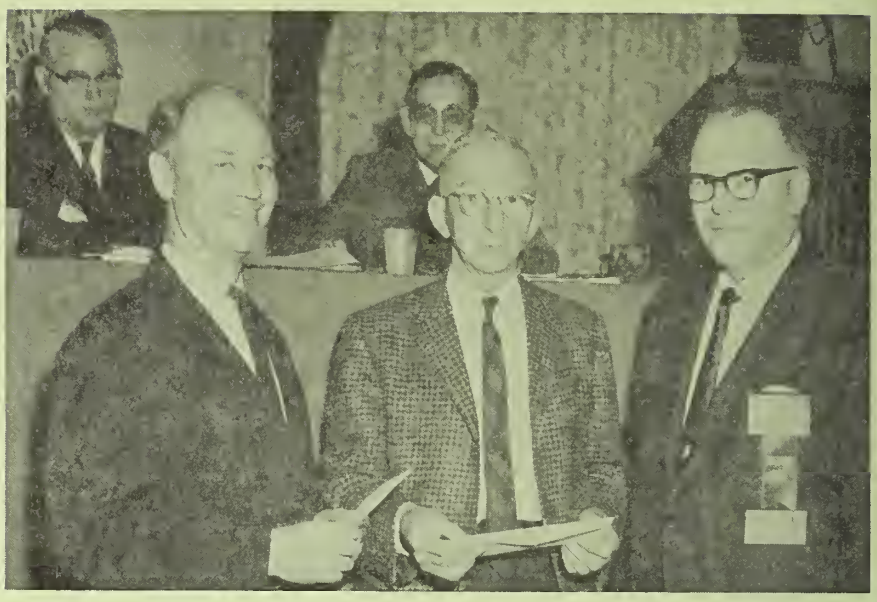

Wisconsin Medical Schools Given Nearly $21,000

Incoming president, Dr. W. D. James, Oconomowoc, is shown presenting checks totaling nearly $21,000 to representatives of Wisconsin's two medical schools. Dean Peter L. Eichman, M.D., (L) of the University of Wisconsin Medical School received a check for $8,576.57. J. W. Rastetter, M.D., (C) assistant dean of Marquette School of Medicine, received a check for $12,124.08. These represented more earmarked and undesignated gifts made by physicians and others to the AMA–ERF for the benefit of medical education. Doctor James (R) is an Oconomowoc general practitioner who on May 15 became the 110th physician to serve as president of the State Medical Society. He is a graduate of the University of Wisconsin Medical School and has served on the Society's Council for 13 years.

House Urges Law on Implied Consent

The SMS House of Delegates, on May 14, made an urgent plea to the State Legislature to adopt implied consent and physician "immunity" statutes to help control drinking drivers in Wisconsin. The full resolution follows:

WHEREAS, In the past 20 years there has been a progressive increase in the highway death toll, despite improvements in highways, automobile function, auto safety devices, safety instruction and driver training, increased numbers of local, county and state traffic monitors and law enforcement personnel; and

WHEREAS, Physicians, in their experiences in treatment of all kinds of automobile accident injuries of lethal and non-lethal nature, have been impressed that a high percentage of such cases are, and have been, in our estimation definitely associated with intake of alcohol; therefore be it

Resolved, That the State Medical Society of Wisconsin (a) reaffirm its earlier stated position of support of the principle of legislation establishing implied consent for the performance of chemical tests on persons arrested for driving motor vehicles while under the influence of intoxicants; (b) support legislation conferring appropriate immunity to a physician who administers chemical tests for intoxication at the request or direction of a law enforcement officer; (c) actively encourage state legislators to enact such laws at the 1969 session.

BACTERIOLOGIST HONORED

Paul F. Clark, Ph.D., Madison, received the Interstate Post Graduate Teaching Award in recognition of his studies of poliomyelitis and other virus diseases of the central nervous system.

Doctor Clark is a prominent bacteriologist and teacher.

SMS Hot Line

COMPREHENSIVE HEALTH CARE COVERAGE for all with direct income tax credits to some who can't pay the full premium has been proposed by the AMA Committee on Health Care Financing of which Dr. L. O. Simenstad, Osceola, Wis., is a member. It calls for pilot projects with a voluntary "community health services fiscal agent" handling the financing, and medical societies to provide peer utilization review and assistance in quality control. Implementation depends in part on AMA's House of Delegates action in San Francisco, June 16-20.

CHIROPRACTORS in Madison want the right to prescribe "limited" physical activity for students in physical education classes. So far, the Madison Board of Education has refused comment, but does accept chiro requests to "excuse" a pupil from phy-ed.

PRIORITY HEALTH NEEDS in Wisconsin are being determined by the Wisconsin Advisory Council on Comprehensive Health Planning. Dr. George Handy, Madison, director of the planning program in Wisconsin, has called upon each of the 37 Advisory Council members (including two practicing physicians) to itemize what they see as top priority health items for planning and action. This is regarded as a first step in the overall planning program.

HEW SURVEY TEAMS are criss-crossing Wisconsin to get views from providers and administrators on how Title XIX (Wisconsin Medical Assistance Program) is working.

CONTROVERSY IS BREWING over proposed amendments to Public Health Service laws which say 70% of federal funds allocated to states must be used to "support services in communities," such as "prevention or alleviation" of health problems. Fear is that built-in "guarantees" for noninterference with medical practice are on the way out.

LOCAL GOVERNMENT REORGANIZATION may be the next "political miracle" in the making in Wisconsin. State Reorganization was thought hopeless a year ago but is now law. Wisconsin State Chamber of Commerce has launched campaign for local government modernization to halt centralization in Madison and Washington.

SENIOR MEDICAL STUDENTS at Wisconsin and Marquette were guests of the State Medical Society for a "We Like It Here" buffet lunch on their respective graduation days. New MDs and guests totaled nearly 600. Reaction: Excellent.

NEW PHONE NUMBER for all activities of SMS . . . 257-6781 (area 608).

M.D. Guidelines for Highway Accident Blood Alcohol Testing

Introduction

No group is more closely involved in the tragic human toll caused by motor vehicle accidents than the medical profession. A major contributing factor to this toll is the driver who has been drinking. It is further aware that Wisconsin does not at this time have an implied consent law which would apply to all persons licensed to operate motor vehicles. It also knows of the heavy reliance of law enforcement officials on chemical tests for intoxication. The profession is, likewise, aware of its dual responsibilities as citizens and as physicians. Finally, it has been advised that the courts have settled some areas of the law relating to such chemical tests but that other areas remain unsettled.

In light of these considerations, and to permit the medical profession to fulfill its responsibilities to government as well as to those injured in traffic accidents, the House of Delegates adopts the guidelines which follow as an assistance to all physicians in the state who may be called on to take a blood sample by a law enforcement officer.

The guidelines are also based in part on the understanding that in the near future law enforcement officers throughout the state will have available to them equipment permitting the taking of chemical tests from an accused driver which do not require the services of a physician.

These guidelines were adopted May 14, 1968, by the House of Delegates of the State Medical Society of Wisconsin for distribution to all members of the society. The society was authorized to revise the guidelines from time to time as experience and circumstances may indicate.

It is to be clearly understood that the guidelines apply only when all of the following facts are present:

a. The person to be examined has been injured in a motor vehicle accident and has been brought to a hospital or to a physician's office for examination and any needed treatment;

b. The injured person has been arrested on a charge growing out of

(Continued on next page)

Form A

DIRECTION TO DRAW BLOOD

The undersigned, _____, a law enforcement officer of the state of Wisconsin, hereby directs _____, M.D., to draw blood from the accused, _____. The undersigned arrested the accused at ____:____ __.M. for alleged criminal acts involved in driving a motor vehicle while under the influence of an intoxicant, and the blood drawn will be used to perform a clinical test to determine his blood alcohol level, which may be used as evidence against him. The undersigned has informed the accused that he is under arrest, that this test will be conducted and its purpose.

Dated _____, at ____:____ __.M.

Witnesses:

_____ _____

Name

_____ _____

Title

Form B

AUTHORIZATION FOR DRAWING BLOOD

The undersigned, _____, hereby consents to the drawing of blood from him by or under the direction of _____ _____, M.D. The undersigned understands that the blood is being drawn for the purpose of determining its alcoholic content, and that the results of this determination may be used in connection with his prosecution on criminal charges involving driving while under the influence of an intoxicant.

Dated_____.

Witnesses:

_____ _____*

Name

_____

* If unable to sign name, but capable of giving consent, so note in this blank and have witnesses sign as having witnessed his oral consent.

driving while under the influence of an intoxicant. (It is the responsibility of the law enforcement officer to tell the physician that the injured person has been arrested); and

c. The officer directs the physician to take a blood sample from the injured person.

Recommended Guidelines

1. **Written Direction to Physician.** The physician should present to the officer a form similar to that attached and marked as "Form A," explaining that he will not proceed until the direction has been signed.

2. **Written Authorization from Injured Person.** Wherever possible, and if the physician believes the injured person has the capability of giving authorization, the physician should obtain the written authorization of the injured person by presenting for signature a form similar to that attached and marked as "Form B."

3. **Injured Person Willing but Unable to Write.** If the injured person is conscious, but unable to sign, and gives his oral consent to the taking of a blood sample, and in the physician's judgment is capable of giving consent, such facts should be noted by two witnesses, if at all possible.

4. **Injured Person Unconscious.** In this situation, the physician need not take a blood sample solely on the direction of the law enforcement officer. If he does take a blood sample in the course of his physical examination, its production as evidence may be required later.

5. **Injured Person Refuses Test.** It is a matter of professional judgment whether to proceed with the taking of a blood sample where the injured person refuses by words or by physical resistance to authorize the procedure.

6. **Cooperation With Law Enforcement Officers.** Working arrangements with local law enforcement agencies should be developed by local medical societies as rapidly as feasible. This would include the establishment of procedures for the preservation of blood samples for evidentiary use.

Notes to Physicians:

1. The physician may be called on to take a blood sample in a place other than a hospital or physician's office. The physician must decide whether, as a matter of professional judgment, such a place and its equipment meet acceptable hygenic standards. If not, he should not take the sample there.

2. Wherever feasible, the physician should encourage law enforcement officers to employ chemical tests other than those calling for the taking of a blood sample.

President-elect Callan Presented to the House

Dr. Robert E. Callan, Wauwatosa, is welcomed by the House of Delegates as he became president-elect of the State Medical Society on May 15. A graduate of Marquette Medical School and a faculty member there, Doctor Callan is past president of the Wisconsin Academy of General Practice. Currently a delegate in the House of Delegates, he served for six years as its speaker.

URGE LOCAL QUACKERY MEETINGS

Local seminars on quackery were advocated by the House of Delegates in May. Previously, the Society sponsored a statewide conference. Quackery costs the public of Wisconsin an estimated $40 million per year.

In other action, the House asked the Society to seek legislation with improved standards for school bus operators.

Clarify Role of Allied Personnel in Total Health Care

Clarification of the role of the allied health professions and paramedical personnel in total health care was requested in an appeal of the House of Delegates of the State Medical Society of Wisconsin to the American Medical Association.

Pointing to the new and emerging paramedical health care occupations which have the potential to increase the efficiency of physicians, the House called upon the AMA to outline the responsibilities and limitations of each group with regard to licensure, privileged communications, legal responsibilities, hospital privileges, patient records, and other factors that bear on the patient–physician relationship in the interest of health care of high quality.

The Wisconsin delegation to the AMA in mid-June will appeal for guidelines to advise state and county medical organizations in dealing with the emerging paramedical disciplines.

Dr. Kief Compares Health Costs with Consumer Spending

The outgoing President of the State Medical Society, H. J. Kief, M.D., Fond du Lac, called for "new leadership in health expenditures control."

Speaking at the opening session of the Society's House of Delegates, the chief policy-making body, Doctor Kief urged the creation of a Comprehensive Health Expenditure Commission (CHEC) as a means of providing some "economic relief to the patient."

The proposed Commission would include physicians, hospital trustees and administrators, nurses, pharmacists, dentists and others involved in health care.

Doctor Kief challenged President Johnson's "shocked" reaction to rising costs of medical care which were reported to be 6.6% in 1966.

He cited the recent 6% wage increase settlement of the telephone strike and annual building cost increases of 10% as evidence that all costs which comprise the "cost of living" have been rising steadily.

Doctor Kief cited government reports indicating that the average consumer spends only $1.77 of each $100 of consumer purchases for doctor fees and a total of $6.70 out of each $100 on health care.

He said, "The consumer spends as much on tobacco, liquor and jewelry as for all health care, twice as much on cars as on health, and four times as much for recreation as for doctor bills."

As for charges that doctors overuse hospitals and provide unnecessary treatment, Doctor Kief declared that the Medical Society would not support a physician who makes "an unconscionable or unreasonable charge for his services."

He cited the Society's grievance procedures and declared, "Let those in Wisconsin who feel victimized say so, and I pledge our prompt and thorough action."

Presidential Citation Awarded Leo C. Massopust

Outgoing president, Dr. H. J. Kief, Fond du Lac, is shown presenting the "Presidential Citation" to Leo C. Massopust, Milwaukee. He is an outstanding scientific photographer, artist and editor who pioneered work with infrared. Doctor Kief completed his term as president of the Society at this meeting.

Seven Reports Get OK of House

Reports on resolutions with wide ranging effect upon health care in Wisconsin were adopted by the SMS House of Delegates in May:

Among them were decisions to:

1. Conduct institutes in the care of the newborn and premature infant under the auspices of the Division on Maternal and Child Welfare of the State Medical Society.
2. Continue conferences with physicians to determine unmet needs in the care of the handicapped child as a part of the cooperative program with the Bureau of Handicapped Children of the State of Wisconsin.
3. Accept a report of the Division on Chest Diseases, noting especially that information concerning programs on chemoprophylaxis and INH as therapeutic agents can be obtained from the Chairman of the Division, Henry A. Anderson, M.D., River Pines Sanitorium, Stevens Point.
4. Urge consideration of a guide for preschool hearing tests to be prepared by the Division on Ear, Nose and Throat.
5. Endorse the work of the Division of Ear, Nose and Throat with other agenices on the problem of registering and certifying hearing aid dealers.
6. Endorse publication of a guide for visual screening programs for school children through the Society's Division on Vision.
7. Recommend that the Committee on Occupational Health sponsor a conference on pesticides and insecticides.

Houghton Award to Two Senior Students

Awards were given to two Wisconsin medical students on May 14 who show "high promise of becoming a complete physician."

One award went to James Renne of Kenosha, who is a student at the University of Wisconsin Medical School.

The other went to C. Robert Stanhope, Milwaukee, who attends Marquette School of Medicine.

The awards were given at the second session of the House of Delegates.

The plaques, known as the "John H. Houghton, M.D. Award" are provided by a fund initiated by the late Dr. Houghton of Wisconsin Dells.

The awards are given by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

On hand to present the plaques was Dr. W. D. Stovall, Madison, president of the Foundation.

The award honors those "who, through scholastic excellence, extracurricular achievement and interest in medical organization, show high promise of becoming a complete physician."

The purpose of the Houghton award is to stimulate the interest of medical students in the social and economic aspects of health care, as well as the scientific aspects. Houghton believed that such a well-rounded physician, one who is interested in the broader sense of health care, would, in fact, become a better doctor of medicine.

MAY GRADE HOSPITAL EMERGENCY ROOMS

Hospital emergency rooms may soon be graded to tell the public the type of emergency care that each provides.

The SMS House of Delegates asked that the Society's Council keep close watch of the development.

The Commission on Hospital Relations and Medical Education and the Commission on Safe Transportation of the Society have been collaborating in preliminary classification of hospital emergency rooms according to their reports.

Several national groups, including the AMA, have supported such a move.

One of the Society's commissions has expressed the "strong belief" that some inspection system should be established to classify hospital emergency rooms which would indicate to the public and all providers of emergency service precisely the facilities for emergency care available in each.

HOUSE ACTIONS COVER BIRTH TO DEATH

Actions of the House of Delegates ranging from birth control to death benefits highlighted the 127th Annual Meeting of the State Medical Society in Milwaukee in May.

Among the actions of interest were:

1. Reaffirmation of the society's position and support of the principle of legislation to remove birth control information and devices from the definition of "indecent articles."
2. Recommendation for the establishment on a local or regional basis of medical advisory boards to the State Motor Vehicle Operators Licensing Department. They would advise on medical factors concerned with the issuance or renewal of driver licenses.
3. Requested WPS to provide health insurance protection for widows and dependents or children of physicians through the physicians group, at the same level as was available prior to the doctor's death.
4. Adoption as official policy of the Society the position of the Division on Nervous and Mental Diseases "that the total care and responsibility for patients with mental illness, rests primarily with a physician who alone holds an unlimited license to care for the sick."
5. Rejected a resolution advocating redistricting of the State Medical Society.
6. Rejection of mandatory immunization, and support of educational efforts on the values of immunizations.
7. Called for a statewide conference to be held in the fall of 1968 on the shortage of physicians.

WPS REPORTS STRONG GROWTH IN 1967

"A strong growth pattern" was reported by WPS for 1967.

In a report to the House of Delegates, the Commission on Medical Care Plans noted that WPS–Blue Shield had a 14% gain in surgical medical contracts last year, a 20% gain in hospital contracts and a 22% gain in major medical.

WPS–Blue Shield now provides coverage for nearly 475,000 persons in Wisconsin.

Dr. James Installed As New President

The incoming President of the State Medical Society cautioned doctors to stop "speaking only to doctors" and urged them to take an active role in civic affairs.

Dr. W. D. James, Oconomowoc, addressed the first session of the Society's House of Delegates. He said, "It has often been the habit of physicians to take no part in political activities and to pretend that as professional men, we, physicians are removed from the hurly-burly and strife of decision-making in a democratic society."

He warned that doctors "dare not wait until the initiative is taken completely out of our hands by other groups."

He called for more involvement by physicians in hospital costs, insurance plans and government health programs.

Elect 20 MDs to Society Posts

Twenty physicians were elected to official posts in the State Medical Society during its 127th Annual Meeting.

Elected as officers were Robert E. Callan, M.D., Wauwatosa, president-elect; F. L. Weston, M.D., Madison, treasurer; and T. J. Nereim, M.D., Madison, vice-speaker of the House.

Elected chairman of the Council was Dr. E. J. Nordby, Madison. In other elections, Dr. James M. Sullivan, Milwaukee, became vice-chairman of the Council and Dr. V. S. Falk, Jr., Edgerton, was reelected medical editor of the *Wisconsin Medical Journal,* while Dr. D. N. Goldstein, Kenosha, was reelected editorial director.

Reelected as councilors were M. F. Huth, M.D., Baraboo, third district; J. E. Dettmann, M.D., Green Bay, sixth district; J. W. Boren, Jr., M.D., Marinette, eighth district; E. P. Ludwig, M.D., Wausau, ninth district; W. R. Manz, M.D., Eau Claire, tenth district; S. L. Chojnacki, M.D., Milwaukee, twelfth district; S. W. Hollenbeck, M.D., Milwaukee, twelfth district; and Marvin Wright, M.D., Rhinelander, thirteenth district.

E. P. Rohde, M.D., Galesville, seventh district, was elected to the Council to fill the councilorship vacated by James C. Fox, M.D., La Crosse.

J. M. Bell, M.D., Marinette and E. L. Bernhart, M.D., Milwaukee, were reelected delegates to the AMA. J. C. Fox, M.D., La Crosse and C. J. Picard, M.D., Superior were reelected alternate delegates to the AMA.

NEED MORE "NURSING" NURSES IN WISCONSIN

The lack of nurses "who nurse" prompted the SMS House of Delegates to make a strong appeal for the establishment of diploma nursing schools throughout the state.

The Douglas County Medical Society had introduced a resolution calling attention to the reduction in the number of diploma nursing schools over the years in Wisconsin and citing an increasing deficit of registered nurses to adequately staff existing and expanding health facilities.

As a result, the House of Delegates called upon the State Medical Society to "offer all possible encouragement and help to all communities seeking to establish such schools, and encourage nursing education at all levels, including degree schools, diploma schools, and schools for licensed practical nurses."

At the same time, the House adopted a Clark County Medical Society resolution asking for modification of existing laws pertaining to nurses credentials so as to facilitate the recruitment and employment of well qualified out-of-state nurses.

AMA President Speaks

Dr. Milford O. Rouse, president of the American Medical Association, addresses the annual dinner of the State Medical Society on May 15.

URGE CAREER EFFORTS

Health Career scholarship funds for members of minority groups will be investigated by the State Medical Society as a result of House action on a resolution introduced by the Third Councilor District.

1968 ANNUAL MEETING ATTRACTS 2,342

The future of the Annual Meeting of the State Medical Society and the format of postgraduate medical training will come under special study in 1968–69.

The House of Delegates called upon the Society's Commission on Scientific Medicine to explore a possible change in the format of the Annual Meeting and replacing exhibitor income with a registration fee for physicians who attend.

The Commission believes that more physician attendance is required at scientific presentations and at exhibitor booths. Rental of exhibit space to medical and scientific firms provides a major source of income to support the meeting.

The 1968 Annual Meeting attracted a physician registration of 1,302 plus 1,040 nurses, medical students, residents, interns and others. Total registration was 2,342.

In other action, the House deferred a decision on possible rotation of the Annual Meeting between the cities of Milwaukee, Madison, La Crosse and Green Bay.

MEDICARE SHOULD OK PATHOLOGISTS AS MDs

The efforts of pathologists to be recognized as physicians in government programs were supported by the SMS House of Delegates.

This seemingly incongruous situation arises out of rules and regulations under Medicare. Pathologists have objected to being treated differently under these rules than are other physicians in the payment of services for consultation.

As a result of the House action, the State Medical Society will appeal to the Council on Health and the Department of Health and Social Services of the State of Wisconsin to evaluate the effect and precedence of HEW regulations that do not accommodate special situations such as the consultant physician in pathology.

the wisconsin medical journal

VOLUME 67/NUMBER 7 JULY 1968

Ovarian Pregnancy Removed Via Culpotomy

By CARL J. LEVINSON, M.D., Milwaukee, Wisconsin

■ UNTIL 1941 ONLY 60 acceptable cases of ovarian pregnancy had been found and reported. By 1965 over 200 such cases had been reported. This figure probably indicates a much greater awareness on the part of the physician and pathologist. However, it has been pointed out that many are probably overlooked as corpora hemorrhagica. This incidence (compared to uterine pregnancies) has ranged all the way from 1:11,156 to 1:55,316[1] with most authors quoting an average of 1:25,000 to 1:40,000. Of the ectopic pregnancies, the incidence ranges somewhere between 0.3% and 1.5%.[2]

History

The first case was reported in 1862 by Saint Maurice[3] of Perigord, France. However, it was not until 1878 that Spielgelberg[4] provided the criteria by which all other cases have been judged. These criteria are:

1. The tube on the same side must be intact and separate from the ovary.
2. The gestation sac must occupy the normal position of the ovary.
3. The sac is connected to the uterus by the ovarian ligament.
4. Ovarian tissue is demonstrable in the wall of the sac.

Case Report

This patient was a 27-year-old white woman, gravida 5, para 0323.*

Past History: A pneumothroax in 1941 was associated with a fractured clavicle. The first pregnancy terminated prematurely with the delivery of a living child. The second pregnancy terminated prematurely as a result of abruptio placenta with the delivery of a child that survived. The third pregnancy terminated at term with the delivery of an infant weighing 4 lb 14 oz. Two spontaneous abortions followed in succession, both of them complete and not requiring curettage.

Present Illness: On Dec. 26, 1963, the patient appeared in the office because of irregular vaginal bleeding and lower abdominal pain. Her last normal menstrual period had been the "end of November;" she had begun to spot on Dec. 6 and had continued through the month of December. There were no signs nor symptoms of pregnancy. On pelvic examination the corpus was small and deviated to the right. The left adnexum contained a 7 to 8 cm cystic mass which was transversely elongated. The patient was warned regarding symptoms of an ectopic pregnancy but a pregnancy test was negative. A week later the pain had subsided, the spotting had continued, and the mass was somewhat smaller at 5 to 6 cm. The patient stated that she had had what seemed like a normal period on Feb. 10. On Feb. 27, 1964, pelvic examination revealed the cystic mass in the left adnexum persisted at 5 to 6 cm.

Operation: A culpotomy for exploration of a left ovarian cyst was performed on Mar. 13, 1964. Entry into the cul-de-sac was made with ease. A moderate amount of yellowish fluid and a small hemorrhagic piece of tissue about 1 cm in diameter was found lying free in the cul-de-sac. Higher up in the cul-de-sac, but also lying free, was a larger hemorrhagic mass about 3x3x1 cm. The left ovary was three times normal size and contained a 4 cm hemorrhagic cystic mass that was filled with blood and on section contained a 5 mm structure resembling a very early fetus (Fig 1). The entire hemorrhagic area was resected and the defect in the ovary corrected with interrupted sutures. The tube was inspected and found to be normal in all respects. The uterus, opposite ovary and tube were also normal.

* With reference to the multiparity formula utilized, the total gravidity is 5, the first figure in the parity representing full-term deliveries, the second figure premature deliveries, the third figure represents abortions, and the fourth figure indicates the number of living children.

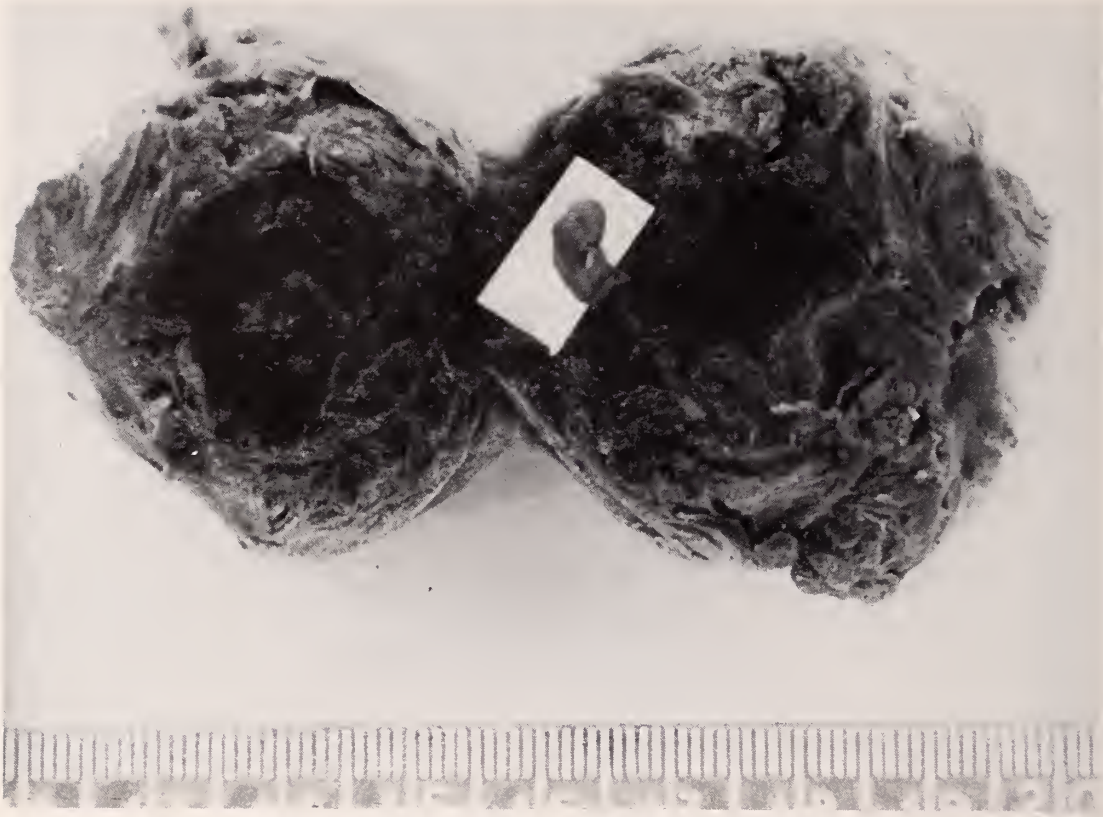

Fig. 1—Cut surface of ovary with cystic cavity and embryo.

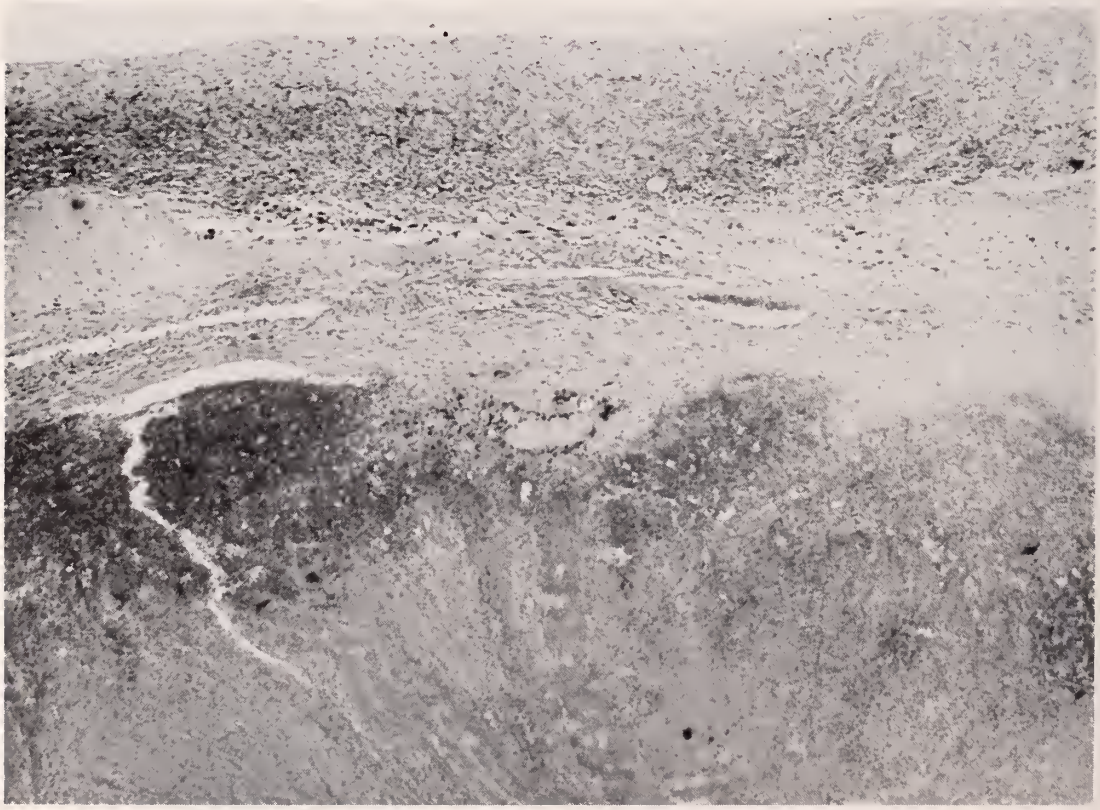

Fig. 2—Ovarian tissue showing trapped villus. (x100)

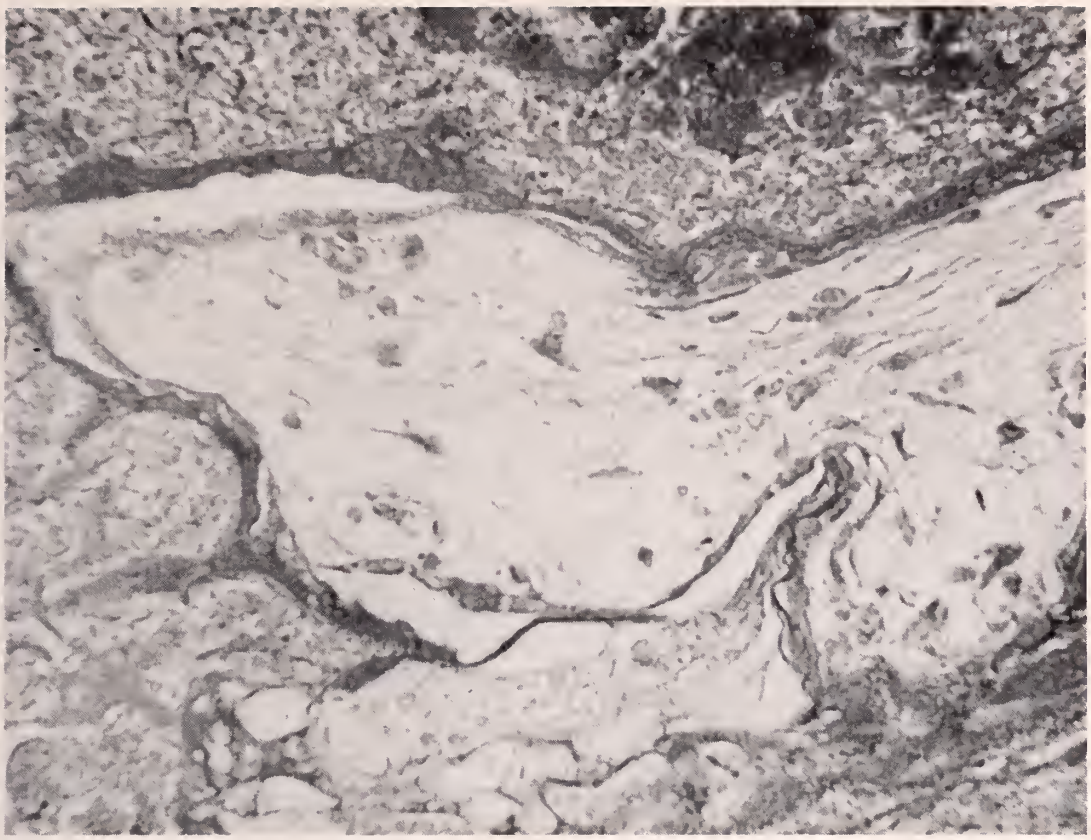

Fig. 3—High-power view of villus in ovarian stroma. (x450)

Pathology Report: "A mass 3.5 by 4 by 4 cm. This is covered by a smooth and delicate membrane on the outside, some of which is friable. There are scattered cysts within the surface of the major cyst. On cross-section the wall of the cyst is thick and tan colored. It contains hemorrhagic, partially organized material. The wall is 1.8 cm in thickness. The inside of the cyst is 1.5 cm in diameter and lined by smooth tissue. Within the cyst is an apparently well-formed embryo 0.8 cm in length on an umbilical cord about 1 cm in length. Sections of the left ovarian cyst reveal ovarian stroma. This contains an occasional corpus atreticum. There are also occasional central cysts lined with a fibrous tissue containing red cells. The major portion of the wall is lined by nonspecific granulation tissue. The contents of the major cyst are fibrinous material. Trapped within this material are the ghost outlines of placental villi (Figs 2 & 3) having the usual elongated oval shape. There is a suggestion of differentiation into trophoblast stroma. However, the villi are entirely necrotic and no viable villi are noted. It is of interest that at the edges of the cyst is some viable material containing enlarged hyperchromatic nuclei somewhat suggestive of decidua." The final diagnosis was "secretory endometrium, ovarian pregnancy of left ovary."

Follow-up: The patient made an uneventful postoperative recovery. A year later she was seen in the office because of amenorrhea and a diagnosis of pregnancy was made. Subsequent delivery was without complication.

Mechanism

There is a good deal of confusion (probably due to a lack of definitive knowledge) as to the exact means by which the fertilized ovum begins development within the ovarian tissue, if indeed that is where it commences. The following major theories (with some minor variations) have been proposed in the past: (1) the egg is retarded in its escape from the follicle and is fertilized there;[5] (2) when the follicle ruptures, the egg is not extruded into the peritoneal cavity but into the ovarian stroma whereas the opening into the peritoneal cavity provides an area of entrance for the sperm;[6] (3) the fertilized egg may implant and grow on the cortex of the ovary (perhaps, it has been suggested, in an area of endometriosis);[7] and (4) fertilization of the egg may take place within the tube or peritoneal cavity from whence it reimplants upon ovary.[8]

As a result of these many theories, several

types of classification for ovarian pregnancies have been proposed. Two of these are presented:

A. Classification of Ellis[9]
   1. *Primary.* (Fertilization and nidation take place in the ovary according to the site, i.e.:
      a. Intra-follicular
      b. Supra-follicular
      c. Interstitial
      d. Superficial.)
   2. *Secondary* (Fertilization and some development take place elsewhere and then the ovum becomes implanted in the ovary.)

B. Classification of Baden–Heins[10]
   1. *Primary ovarian pregnancy.* (The ovarian tissue forms an intact layer over the embryonic tissue.)
   2. *Combined ovarian pregnancy.* (The ovarian stroma forms a portion of the adjacent implantation tissue wall.)

The rarity of the ovarian pregnancy is not difficult to understand. The mechanics of ovulation seem to be such that the ovum is propelled from the ovary in a somewhat explosive fashion. In addition, there appears to be some anatomical or chemotactic or hydrodynamic force that delineates the route of the ovum from the ovary to the tube. Furthermore, at the time of its explusion from the ovary, the ovum is presumably too immature for fertilization; and there has been improper or inadequate secretion of the corpus luteum, which is necessary for proper nidation. (Actually, however, if implantation occurs in the ovary, it is much the same as it is in the uterus, but without decidual formation.)

Termination

The vast majority of ovarian pregnancies terminate within the first trimester by rupture. (This has been estimated at 75%.[2] However, there is no way of estimating the number of ovarian pregnancies that are never discovered at all.) Another 12.3% terminate in the second trimester. Approximately 12.2% enter the third trimester; some of these may even reach term (proportionately more ovarian pregnancies come to term than do tubal pregnancies).[11] There is one report of an ovarian twin[12] pregnancy. Others have terminated in lithopedion formation and occasionally in hydatidiform mole.

Differential Diagnosis

Ellis has very neatly delineated the possible diagnoses which may be confused with ovarian pregnancy. (It should be pointed out, in all fairness, that most of these cannot be distinguished until surgery, and very often not until the pathologist has opened the specimen.) If the ovarian pregnancy has ruptured into the peritoneal cavity, then it may be confused with: (1) an ovarian cyst; (2) an unruptured tubal pregnancy; or (3) a pedunculated fibroid.

Summary

A case report has been presented of an ovarian pregnancy. In addition to the unusual nature of the pathologic entity, one unique feature of the case was the operative approach via culpotomy.

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CORONARY ATHEROSCLEROSIS . . .

A Metabolic Defect or a Natural Process of Aging?

By JAMES W. JEFFERSON, M.D., Madison, Wisconsin

■ THE RELATIONSHIP of diet to serum cholesterol, atherosclerosis, and coronary heart disease is one of the most controversial topics in medicine. Inasmuch as coronary heart disease accounts for approximately 30% of all deaths in American males between the ages of 45 to 54 years, and is the cause of death of over 500,000 Americans per year, it behooves us to continuously explore and reexplore all possible mechanisms of its pathogenesis.

It is projected that if coronary artery disease could be eliminated as a cause of death, life expectancy at age 30 would increase an additional 12.4 years beyond its current predicted level of 71.1 years for the American male.

Atherosclerosis is generally felt to be a disease of complex etiologies. Epidemiologic studies have established that high risk factors in the development of coronary atherosclerosis include elevated serum cholesterol levels, hypertension, the presence of diabetes mellitus and obesity, a "positive" family history of coronary or peripheral vascular disease, the lack of a sustained exercise program, and cigarette smoking. It has also been relatively well established that in the absence of high fat and high cholesterol diets, advanced or premature atherosclerosis rarely occurs, regardless of the presence of other factors.

In view of the vast amount of work published in this area, often of a contradictory and confusing nature, a review of the pertinent literature incriminating dietary cholesterol and fat in the genesis of atherosclerosis and coronary heart disease seems appropriate. Ultimately, one can speculate on the basic question of whether dietary modification can prevent coronary atherosclerosis and resultant myocardial infarction. Before examining the more specific dietary aspects, one should first be aware that genetic predisposition plays a major role in the rather wide individual variability of serum cholesterol, both in man and animals. Thomas,[1] studying healthy medical students at Johns Hopkins, found serum cholesterol levels greater than 300 mg/100 ml in 9% of the students. Of these, 32% had a parent with clinical coronary heart disease.

Prichard[2] showed that in the absence of a significant difference in blood lipid levels, the White Carneau pigeon will predictably develop advanced and premature atherosclerosis, with particular involvement of the coronary arteries. Show Racer pigeons, on the other hand, develop virtually no atherosclerosis. A lessening of plaque formation occurred in the White Carneau following therapy with polyunsaturated oils.

Page,[3] in a recent review of atherosclerosis, noted that *in vitro* cultures of intimal vascular cells from individuals with established atherosclerotic disease showed an increased susceptibility to lipid incorporation, as compared to intimal cells from atherosclerosis-free patients. Two types of human intimal cells have been established, the atherophil and the fibrophil. Atherophils, taken from normal areas of blood vessels containing advanced atheromata, show a high capacity for incorporating blood lipids, and eventually become atherocytes, or foam cells. If the tissue culture is continued, the atherocytes eventually die and are replaced by fibrocytes, a different type of cell arising from the fibrophil. This process closely resembles the process of spontaneous atherosclerosis, with early intimal fat infiltration and eventual fibroplaque formation.

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Paper submitted by Richard H. Wasserburger, M.D., Chief, Cardiology Service, VA Hospital, Madison, who commented: "These data were presented by Doctor Jefferson (a resident in cardiology) at the Madison VA weekly Medical Journal Club. They were felt to be of sufficient scope and interest to warrant consideration of publication in the WISCONSIN MEDICAL JOURNAL (and its Editorial Board concurred), for we, as physicians, must take a determined stand to do what we can to stem the ravages of our medical epidemic, namely *atherosclerosis*. We might start by drastically changing ours, our patients', and our children's eating habits."

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Atherophilic cells are normally present in intimal cultures of aortas and coronary arteries from infants and fetuses, and it is possible that the relative number or degree of activity of these atherogenic cells determines whether a person, when exposed to a lipid rich diet, will be a high or low risk candidate for coronary heart disease.

The known predilection of the coronary arteries to atherosclerosis, particularly at "stresspoints," may well be the result of the constant "pounding" of these vessels with each heart beat, much as intimal trauma from any source, viz. hypertension, endotoxins, etc., predispose these cells to lipid deposition. Add to this a fat-laden blood stream and the beginning of atherosclerosis is at hand.

Animal experimentation has contributed significantly to the understanding of the role of diet in atherosclerosis. In the early 1900s Anitschkow[4] demonstrated that a high cholesterol diet was atherogenic for the rabbit. Since that time, atherosclerosis has been produced in all species of laboratory animals, including primates. Buchwald[5] demonstrated that when rabbits are fed a high cholesterol diet, they will develop advanced coronary atherosclerosis and 50% will eventually have myocardial infarctions in association with all stages of plaque formation, hemorrhage, ulceration, and thrombosis.

Recent work done at the University of Chicago has shown that 75% of Rhesus monkeys will develop advanced atherosclerotic disease after two years of eating a typical American diet, as opposed to a 10% to 15% incidence in monkeys fed a low cholesterol, low saturated fat diet. The gorilla, under natural conditions, is particularly free of atherosclerosis, yet like the Rhesus monkey, if fed a high fat, high cholesterol diet, typical coronary artery atherosclerosis develops. In short, animal experimentation has shown the essence of an atherogenic diet to be one which is high in cholesterol and saturated fats and low in polyunsaturated fats. On the other hand, atherosclerosis has also been demonstrated in blue fin tuna, pelicans, and seals despite a diet high in polyunsaturated fat and low in saturated fat.[6]

Spontaneous atherosclerosis which closely resembles coronary atherosclerosis in man has been observed in swine, killer whales, and certain primates namely baboons, squirrel monkeys, chimpanzees, and marmosets.

Epidemiologic studies have also contributed towards an understanding of the role of diet in coronary heart disease. As early as 1916, DeLangen[7] reported low serum cholesterol levels and a low incidence of angina pectoris in Javanese eating a native diet, while Javanese working on Dutch ships and eating European food showed an incidence of angina and a level of serum cholesterol approaching that of their European counterparts.

Marked contrast of dietary habits can be found in people of different countries and different areas, and also among classes within countries. In general, in the economically more developed countries such as the United States, the diet tends to be high in animal foods and dairy products, and, therefore, high in total fat, saturated fat, cholesterol, and refined carbohydrates. The serum cholesterol, triglycerides and beta-lipoprotein levels tend to increase with age, and as pointed out in the Framingham study,[8] the average serum cholesterol in males aged 30 through 60 was 220 mg/100 ml, with 5% being greater than 280 mg/100 ml and 5% being less than 160 mg/100 ml. As determined in various laboratories in this country, the upper limits of "normal" for serum cholesterol ranges from 250 to 280 mg/100 ml.

Vegetarian diets, which are low in calories and animal foods and, therefore, low in cholesterol, fat and refined carbohydrates, are the rule in economically poor countries. Mean serum lipid levels tend to remain low throughout life and the incidence of coronary heart disease and severe atherosclerosis is low. Low serum cholesterol levels have been demonstrated in manual laborers in India (average of 125 mg/100 ml) as well as in Korean monks and Guatemalan laborers (average of 140 mg/100 ml).[9] Lowenstein[10] of the World Health Organization, found 26 different racial or ethnic groups throughout the world who exhibited low incidence of coronary heart disease. In all but two, the serum cholesterol was low and of these all but two thrived on a diet low in cholesterol and animal fat.

Similar relationships were documented by Ancel Keys[11] in an interracial study in South Africa. The Bantu, a low socio-economic group, derive 17% of their total calories from fat and had an average serum cholesterol of 166 mg/100 ml. The Cape Colored,

of intermediate socio-economic status, derive 25% of their calories from dietary fat, and had an average serum cholesterol of 204 mg/100 ml, whereas the European, or the upper social class, ingesting a high fat diet, (35% calories from fat) had an average serum cholesterol of 234 mg/100 ml. In order to eliminate racial factors, each group was subdivided on the basis of income and it was found that similar income groups had approximately the same serum cholesterol levels and the same percent of their diet consisted of animal fat. One cannot deny that differences in physical activity, emotional tension and smoking habit may be contributing factors, yet it is difficult to deny the fundamental role of diet.

At the Groote Schuur Hospital in Cape Town, South Africa, Vogelpoel[12] demonstrated a racial distribution of myocardial infarction that correlated well with the study of Keys. In a review of 5,000 electrocardiograms, a myocardial infarction incidence of 0.9%, 6.8%, and 13.5%, was found in the Bantu, the Cape Colored and the European, respectively.

Amazon tribesmen, who live on a diet of fish, fowl and nuts, and which is almost free of meat and dairy products, have a serum cholesterol level of less than 100 mg/100 ml.[13] Data on their incidence of coronary atherosclerosis are not yet available.

Studies of populations that have changed diet as a result of migration also lend support to the fact that dietary fat and cholesterol are seemingly related to coronary heart disease. Ancel Keys[14] showed that the Japanese peasant laborer has approximately one-tenth the number of heart attacks as does the average American male. Their diets contain about 10% of the total calories as fat, compared to 40% in the typical American diet. In Japanese who had immigrated to Hawaii, with an associated increase in dietary fat intake, the coronary rate was greater than in their counterpart in Japan, but less than that of Caucasians living in Hawaii. Japanese living in the United States, with a still higher dietary fat intake, exhibited a further increase in coronary heart disease. In fact, atherosclerotic heart disease is the leading cause of death among Japanese Nisei living in California.

The incidence of coronary heart disease in males of Italian ancestry hospitalized in a Boston city hospital, although of similar proportions to men of other ancestry, was much higher than in Italians residing in Italy. Similar epidemiologic studies in Israel[15] showed that Yemenite Jews had lower serum cholesterol levels than immigrant Jews from Europe. This difference, however, decreased with the time the European Jew spent in Israel, during which time both groups were exposed to similar diets.

A retrospective study in Norway during World War II[16] revealed that when the fat intake was markedly curtailed by enforced food rationing, there was a gross decrease in serum cholesterol levels and in mortality from coronary heart disease. One should not generalize, however, as it was noted in England that the coronary heart disease death rate began to increase in 1943, even though rationing continued until 1946.[17]

The relation of obesity, per se, to atherosclerosis is less well defined. Keys[18] found that the distribution of obesity in coronary heart disease differed little from that in the general population. He compared English and Italians and found the former to have higher serum cholesterol levels and a higher incidence of coronary heart disease although they tended to be more obese. However, an excessive caloric intake is generally associated with higher serum cholesterol levels and an effective reducing diet will usually lead to a decrease in serum cholesterol. Being thin, on the other hand, offers little protection against the development of atherosclerosis, as evidenced by the high frequency of coronary heart disease in Finland, where obesity is uncommon but where the diet is high in saturated fats and cholesterol, and where the serum cholesterol levels are high.

To illustrate the lack of a 1:1 relationship between dietary fat and serum cholesterol, the Samburu tribe of North Kenya is worthy of mention.[19] Their dietary fat intake is 60% of their total calories as they live mainly on a diet of milk and meat. Nonetheless, their average serum cholesterol for all ages is 166 mg/100 ml, and this is entirely comparable to the adult Uganda male whose diet contains only 10% to 15% fat. Nevertheless, on the whole, international epidemiologic studies appear to justify the conclusion that diet, serum lipids, and atherosclerosis are closely related.

Epidemiologic studies in the United States are handicapped by the fact that almost all social, economic, and ethnic groups are ex-

posed to diets high in cholesterol and saturated fats. Both mortality and clinical coronary heart disease statistics show that premature atherosclerosis occurs in almost epidemic proportion in virtually all of these groups. There are, however, exceptions. Those Seventh Day Adventists who are primarily vegetarians have both a lower serum cholesterol level and a lower incidence of coronary heart disease than the general population.[20] In a study of Benedictine and Trappist monks in the United States and Canada,[21] the former who eat a typical American diet and have a higher serum cholesterol than the vegetarian Trappists, were shown to have much more coronary heart disease. In either order, the prevalance of coronary disease increased as the hierarchial status and dietary privileges increased.

The prognostic significance of an elevated serum cholesterol in the predisease state has been demonstrated both by the Cooperative Study of Lipoproteins and Atherosclerosis[22] and the Framingham study.[23] In the latter group, a serum cholesterol level greater than 245 mg/100 ml, carries a three times increased risk of developing coronary heart disease in the male, and approximately six times greater in those with levels above 260 as compared with levels less than 220 mg/100 ml. Not only does the risk of coronary heart disease increase with serum lipid level, but so does the risk of immediate mortality following an infarction. The serum cholesterol, beta-lipoprotein and phospholipid levels were all shown to be higher in the disease prone individual, although considerable overlap was present and no lipid value clearly placed an individual in either one group or another. It is not possible to diagnose overt heart disease on the basis of a given serum lipid level but the relative risk of developing coronary heart disease can be estimated.

To place these data in proper perspective, the pathological study of Enos[24] on American soldiers killed in the Korean War will be cited. Gross evidence of coronary atherosclerosis was found in 77% of 300 men having an average age of 22.1 years. Within this group, 20 soldiers had lesions producing more than 50% narrowing of at least one coronary artery (average age 22.6 years). In a similar, but smaller series[25] involving Japanese soldiers (age 20 to 30 years) whose diet was low in total saturated fat, a lesser degree of phagocytized lipids in the atheromatous plaques was found, and there were no plaques found causing greater than 50% narrowing of the coronary arteries.

Can Dietary Modification Bring About a Decrease in Serum Cholesterol, and If So, Which Aspects of Diet Are the Significant Contributing Factors?

It appears that the quality rather than the quantity of dietary fat is the decisive factor in determining blood cholesterol levels. In the majority of normal and abnormal subjects, a high concentration of dietary saturated fats will predictably cause an increase in serum cholesterol, whereas, dietary fats with a high concentration of polyunsaturated fats will result in a decrease in serum cholesterol. Changes in serum cholesterol are usually associated with similar shifts in betalipoprotein and phospholipids as well as in triglyceride levels.

Metabolic studies by Keys[26] have resulted in empiric formulae which allow evaluation of the relative contribution of the various aspects of the diet to changes in serum cholesterol. In one study in which dietary alteration resulted in a 14% lowering of serum cholesterol, it was shown that reduction of dietary cholesterol contributed 31.8%, reduction of dietary saturated fat contributed 54.2%, and increase in dietary polyunsaturated fat contributed 14% to the overall serum cholesterol reduction. Keys also reported the average adult dietary cholesterol intake to be 150 to 350 mg/100 ml per 1,000 calories. By removing all cholesterol from the diet, a reduction of serum cholesterol of 24 mg/100 ml was obtained. However, it is not possible to lower the dietary cholesterol intake to less than 200 mg/100 ml per day and still retain a palatable diet.

Additional data revealed that although a 50% reduction of dietary cholesterol for one year produced no significant change in serum cholesterol, a similar reduction in saturated fats resulted in a rapid decrease of serum cholesterol.[27] Thus, an effective dietary approach to reduction of serum cholesterol emphasizes the need for low saturated fat, low cholesterol and high polyunsaturated fat intake. Modification of animal protein intake, per se, has no effect unless it is drastically restricted.

Yudkin[28] suggested that sugar rather than

fat is best correlated with the incidence of coronary heart disease. He noted that the mean sucrose intake for patients with myocardial infarction or peripheral vascular disease was significantly higher than that of his control group. Stamler,[29] however, feels that at most, carbohydrate is a contributing rather than a pathogenic factor. He argued that if Yudkin's hypothesis were correct, countries with a high sugar consumption, but with low animal fat, low cholesterol diets, should have a high incidence of coronary heart disease. Yet, countries such as Colombia, Cuba, and Venezuela, where the sugar consumption is equal to that of the United States, have shown no increased incidence of coronary heart disease. The military population in Colombia, in fact, has been shown to have an average serum cholesterol of 140 mg/100 ml. Attempts to produce atherosclerosis in animals by means of a high sucrose or high carbohydrate diet alone have been unsuccessful. Cockerels, however, when fed certain carbohydrates in conjunction with a high cholesterol diet, develop blood cholesterol levels above that produced by the cholesterol rich diet alone.[30] Sucrose caused a higher increase in cholesterol levels than did glucose, while both were more effective than starch. These data require further definition.

Various other factors have been shown to have at least a peripheral effect on serum cholesterol levels. Talbott[31] reports that a high salt intake is associated with increased serum cholesterol levels.

Studies of hard and soft water in the United States, Japan, and England[32] have shown an increase in the cardiovascular death rate as the softness of the water increased.

Higher serum cholesterol levels and significant atheromata have been produced in animals who gorge, rather than nibble, a high cholesterol diet. In man, a significant increase in serum cholesterol level occurred after two weeks of gorging food.[33]

Before discussing the more practical aspects of diet, one should have some understanding of the American diet as it is today. Over the past 50 years, both the absolute fat intake and the percent of caloric fat intake have increased by almost 10%. Of the more than 120 gm of fat consumed daily by the average American adult, 42% of this is of the saturated fat variety, whereas, only 15% is polyunsaturated. The remainder consists of mono-unsaturated fat which has little or no effect on serum cholesterol levels. There has also been a marked increase in consumption of simple sugars in association with a decreased intake of carbohydrates, such as cereal, flour and potatoes.

Although this information may well be pertinent, can dietary alteration be practical and effective, and can it successfully be applied to a large group of people without it taking the enjoyment out of eating? More significantly, can such a modified diet decrease the incidence of heart attacks? Most available information suggests that this would be the case.

Since fatty streaks have been found in the aortas of infants and children, it would appear that the most suitable starting point to prevent continued deposition would be at this age. Pomeranze[34] reported that the serum cholesterol at birth is about 75 mg/100 ml. After two months on cow's milk, the infants' serum cholesterol level doubled. On the other hand, infants raised on soy bean milk, which contains polyunsaturated fats, developed no significant change in serum cholesterol levels over a period of many months. Studies of breast fed children produced more variable results. Apparently the maternal diet influences the fatty acid content of breast milk, as illustrated by the fact that the serum cholesterol of breast fed Italian infants was considerably lower than that of American infants.

Green[35] has shown that serum cholesterol can be reduced by 14% in young adults fed commercially prepared fat modified foods for a number of months. Similar studies in institutional elderly subjects[36] resulted in a 12% reduction in serum cholesterol, with a progressive desaturation of depot fat. The prudent diet of Jolliffe[37] was found effective in lowering serum cholesterol through the use of commonly available acceptable foods. Application of this diet as well as modification of other coronary risk factors by members of the New York Coronary Club showed that after four years, the overall rate of newly detected heart disease was 3.4/1000, as compared to a rate of 14.5/1000 noted in the Framingham study, which was used as the control group.

How Should One Modify His Diet?

One of the most lucid and uncomplicated approaches to this topic has been presented by Blakeslee and Stamler in their book, *Your Heart Has Nine Lives.*[9] In general, they suggest that the percent of calories derived from fat should be decreased from 40% to 25% to 30%, that the amount of saturated fat be decreased from 16% to 9% of the total calories, the ratio of polyunsaturated fat be increased so that at least one-third of the total fat calories are of the unsaturated type, and the daily cholesterol intake should be decreased from the average of 650 to 700 to less than 300 mg/100 ml. Finally, the total caloric intake should be modified in order to achieve ideal weight. The reasonable and necessary approach would be to establish a dietary pattern which would eventually become a way of life.

It is essential that one become familiar with the fat and cholesterol content of various foods. Such information is readily available from a table of nutrient values. Dairy products, chiefly butter, sweet cream, ice cream, hard cheeses and whole milk must be de-emphasized and replaced with skim milk, butter-milk, cottage and other low fat cheeses. It is most impressive that one egg yolk contains 234 mg/100 ml of cholesterol and 2 gm of saturated fat. Reduction or elimination of egg consumption is thus a necessity for a successful diet. One eight ounce glass of whole milk contains 32 mg/100 ml of cholesterol and 6.4 gm of saturated fat, whereas, in skim milk these substances are non-existent. The relative merits of various foods and feasible substitutes are shown in Table 1.

Simply stated, most saturated fat in the American diet comes from five main sources: meats, dairy products, eggs, solid fats, and commercial baked goods.

In selected instances, the use of drugs to lower serum cholesterol has been of value.[38,39] Drug therapy should be considered an ancillary measure to supplement a proper dietary program in *certain* selected and relatively uncommon instances (e.g., familial hypercholesterolemia).

Significant reduction of serum cholesterol has also been obtained in animals by means of surgical bypass of the distal one-third of the small intestine.[40] In a limited series,[41] a 40% reduction of preoperative serum cholesterol levels has been attained in man. This procedure remains experimental and its use is restricted to a small group of individuals exhibiting extreme derangement of lipid metabolism.

A common question asked when one considers the application of diet to serum lipids and atherosclerosis is whether atherosclerosis in man is reversible. Investigation in several areas suggests that a certain degree of reversibility can be attained. In patients fed tritiated cholesterol, a significant change took place between the plasma cholesterol and that in the atherosclerotic lesions.[3] In human intimal cell cultures, the cells were noted to ingest large amounts of lipid when exposed to hyperlipemic plasma. If then transferred to a low lipid plasma environment, most of them released their intracellular lipids and again appeared as normal cells.[42] In studies of the undernourished populations of World War II, and also in long term wasting diseases, lipids were the first components of the atheromatous plaques seen to regress. It is hardly reasonable, however, to expect a significant improvement to occur in the advanced, fibrotic

TABLE 1—*Relative merits of various foods and feasible substitutes*

Foods High in Cholesterol	Cal.	SF	Chol.	Quantity	Feasible Substitute	Cal.	SF	Chol.
Cheeses								
Cheddar, processed	105	5.0	32	1 oz	Cottage cheese	30	0.8	1
Swiss	105	4.0	41	1 oz				
Ice cream	135	5.0	35	½ cup	Ice milk	140	3.0	6
Whole milk	165	0.8	32	8 oz	Skim milk	90	0.7	------
Butter	17	1.0	7	½ tsp	Margarine	17	0.5	------
Eggs (whole)	80	2.0	234	1 large	Eggs (no yolk)	15	------	------
Rib roast (untrimmed; 14 gm fat)	144	6.7	36	1 oz	Sirloin tip roast (trimmed; 2 gm fat)	53	0.8	36
These are examples of relatively high saturated fat foods: cake—chiffon, cheese and sponge; waffles and French toast; all untrimmed meats—bacon, frankfurters and liver; pies meringue and pumpkin; and custards.					Cholesterol and saturated fat are practically non-existent in fruits and vegetables and are generally low in seafood.			

Data taken from *Your Heart Has Nine Lives*, Blakeslee and Stamler, Pocket Books, Inc., New York, 1966.

and calcified area of atherosclerosis. Thus, the greatest stress must be placed upon a prophylactic approach to atherosclerosis designed to prevent or impede the formation of atheromata in the early stages, and to prevent further progression of the more advanced lesions.

The multifactorial nature of coronary heart disease becomes readily apparent when one is exposed to the enormous complex of the investigational work that has taken place over recent years. Nonetheless, a review of the available experimental, epidemiologic, and pathologic data makes it difficult to escape the basic and fundamental role played by diet in the pathogenesis of atherosclerosis. In the absence of high cholesterol, high saturated fat diets, and in the presence of serum cholesterol levels of less than 175 mg/100 ml, coronary heart disease is rare.

Although final proof has yet to be established, it would appear that the majority of us and our patients could accomplish much in escaping the mortality and morbidity of coronary heart disease if we were to adopt a definitive and forcible alteration in our dietary habits. Strong support of this conclusion is provided in the recently published study by Leren.[43]

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MECHANISMS OF ACTION OF RADIOTHERAPY AND CHEMOTHERAPEUTIC ADJUVANTS

H. Vermund, MD, PhD, and F. F. Gollin, MD, Section of Radiotherapy, University of Wisconsin Medical School, Madison, Wis.: *Cancer* 21:58–71 (Jan) 1968.

Ionizing radiations alter the structure of intracellular constituents, interfere with their production and cause loss of proliferative capacity and ultimate death of the cell. Attention is presently centered on the deoxyribonucleic acid molecules as the unique, irreplaceable and therefore important target for the ionizing radiation events.

Almost all of the chemotherapeutic agents with antitumor activity also interfere with nucleic acid metabolism, by either directly combining with and altering the deoxyribonucleic acid molecules (e.g. alkylating agents, actinomycins, IUDR, 6-thioguanine) or blocking metabolic pathways for their synthesis (the halogenated pyrimidines, 6-mercaptopurine, actinomycins, methotrexate).

Radiation sensitization of various biological materials has been accomplished with many chemicals such as oxygen, nitric oxide, different alkylating agents, halogenated pyrimidines (FU, IUDR, BUDR), antibiotics (actinomycin, puromycin) folic acid antagonists, synkavit and others.

The mechanisms in some instances appear to involve the initial physical–chemical events, resulting in the formation of radicals in greater numbers or with longer half-lives; in other instances they involve modifications of the vulnerable cellular targets.

In all probability the deoxyribonucleic acid molecules represent the most important targets for both radiation and the sensitizing chemicals. The importance of the DNA is illustrated by the close correlation observed between the amount of DNA-thymine replaced by 5-iodo-2'-deoxyuridine (IUDR) and the radiosensitivity of human bone marrow cells.

The modified DNA is apparently unable to function properly as a template in the reproductive process of the cell and becomes more vulnerable to irradiation.

Through interference with DNA-synthesis 5-fluorouracil appears to sensitize cells to irradiation. By inducing a deficiency in thymine incorporation by 5-fluorouracil, a less stable DNA molecule is formed and is broken more easily when irradiated.

Actinomycin D forms complexes with DNA and prevents messenger RNA formation. Similar complexes are formed by alkylating agents which produce cross-linking and mutations.

Therapeutic compounds interfere with mechanisms of repair of sublethal radiation damage. The extent of such repair can be evaluated by a study of the dose-survival curves after fractionation of the radiation dose. Cell survival is increased if the dose is divided into two or more fractions. The amount of repair depends on the time elapsed between the fractions. This repair or recovery can be prevented by addition of such chemicals as actinomycin D or methotrexate to the medium whereas other compounds, such as 5-FU, have no effect in the regard.

Finally, one has to consider the mechanism of cell number reduction. When administered in sufficient concentrations, many chemotherapeutic agents, notably 5-FU and methotrexate, are capable of destroying large numbers of tumor cells. With intra-arterial infusion of such compounds to the tumor area there will be fewer tumor cells left for subsequent radiotherapy, leaving more favorable conditions for ultimate complete eradication of all malignant cells.

When one deals with malignant tumors, the crucial question is related to the influence of chemical radiosensitizers on the therapeutic ratio. Many chemicals are capable of increasing the radiation-induced regression of animal tumors and prolonging the lives of the tumor-bearing hosts. In many instances, however, such effects have been achieved at the expense of greater damage to normal tissues, and similar results could have been obtained by simple increase in dose of radiation without the addition of chemicals.

Other compounds have been found in greater concentrations in certain tumors than in the surrounding normal tissues. These malignant cells appear to lack some of the enzymes necessary for the catabolism of the compound. Such circumstances should provide the best foundation for increased selective tumor destruction without the simultaneous enhancement of injury to normal tissues.

Certain chemotherapeutic antitumor agents are capable of exerting cytolethal effects on tumor metastases outside the field of irradiation. Under such circumstances a therapeutic synergism develops between the local effects of the irradiation and the systemic effects of the chemotherapy, resulting in prolongation of life.

AUGMENTATION MAMMAPLASTY

By DONALD M. LEVY, M.D., Milwaukee, Wisconsin

■ WITHIN RECENT MONTHS much has been written in the lay press regarding augmentation mammaplasty. The increasing public awareness of this surgical procedure is due in part to the larger number of women who have sought enlargement of their breasts and to the newer methods of plastic surgery which have made the operation technically easier and the results more consistent.[1]

In our present society as well as in ages past, a woman's breast is a sign of her femininity. A woman with small breasts will sometimes feel self conscious and embarrassed regarding the proportions of her breasts and feel that she is not as feminine as other women with larger breasts or as desirable to members of the opposite sex. Emotional problems can sometimes develop because of this feeling of inadequacy. Plastic surgery can offer these women increased breast dimensions and thereby reduce their feelings of feminine inadequacy.[2]

Women seeking augmentation mammaplasty do so because of mammary hypoplasia, which is sometimes a familial trait, because of gross asymmetry of the breasts, and because of post-partal atrophy in which many women who have well proportioned breasts prior to pregnancy find that with each successive pregnancy the size of the breasts diminishes. Beneficial results can be obtained in all the above categories by the use of augmentation mammaplasty if the expectations from the operation are realistic.

In recent years the use of augmentation mammaplasty has proven useful in those women with cystic dysplasia of the breast who face simple mastectomy.[3] The classic simple mastectomy for benign lesions leaves a cosmetic deformity, a tender scar, and, not infrequently, an emotional depression, all difficult to treat. Many women who have such severe cystic dysplasia that simple mastectomy is warranted or have had so many biopsies that simple mastectomy is indicated can now be treated by a mammary adenectomy through an inframammary incision with preservation of the nipple and an immediate augmentation mammaplasty can be performed. The diseased breast tissue is thus removed but the breast and the breast contour are maintained and very often improved. No longer do women with this problem have to face a simple mastectomy with its dread physical and emotional sequelae. In addition, the submammary incision allows excellent exposure and can be readily modified to a radical mastectomy incision if examination of the gland reveals carcinoma.

Fig. 1—*Left:* Diagram showing step-like incision through skin and subcutaneous tissue to pectoral fascia. Creation of pocket beneath breast tissue. *Right:* Prosthesis in place beneath breast tissue.

The procedure of augmentation mammaplasty as it is now performed consists of the insertion of a prosthesis through a small inframammary incision to lie between the breast tissue and the pectoral fascia.[4,5] The prosthesis is made of a soft silicone container filled with a semifluid silicone. Since the prosthesis is inserted deep to the breast tissue neither the breast glandular or ductal structure is disturbed, thus not interfering with the secretory function of the breast. For this reason with subsequent pregnancy the patient may nurse her child if she so desires. Because of the structure and the semi-fluid nature of the prosthesis, the contour of the breast is maintained and the texture and consistency of the breast remains normal.

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Fig. 2—Preoperative views showing bilateral mammary hypoplasia.

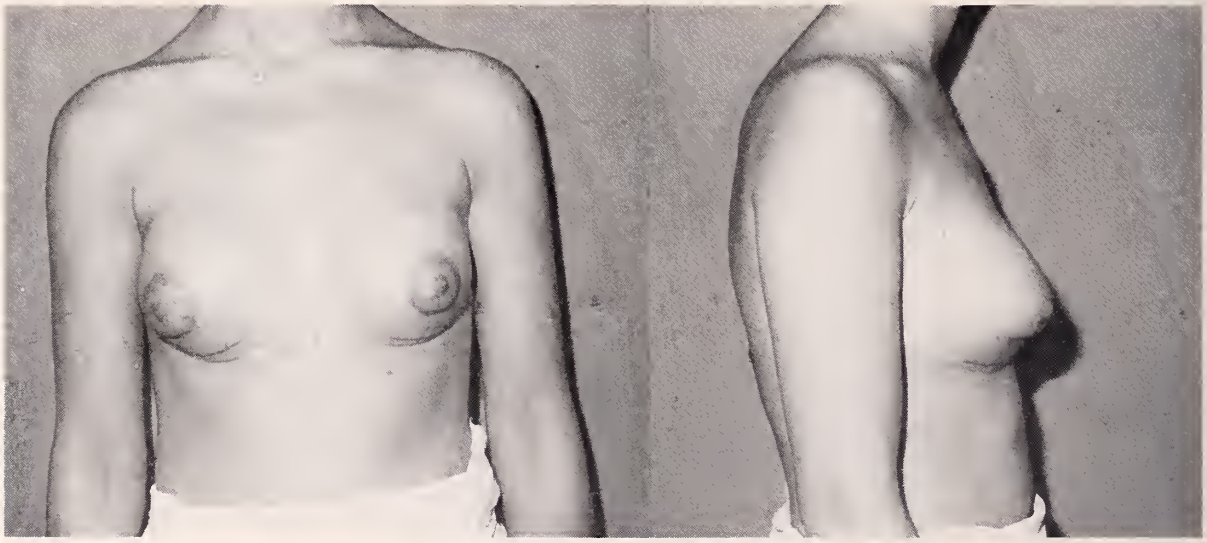

Fig. 3—Postoperative views following insertion of silicone prosthesis.

Fig. 4—Preoperative views showing post-partal mammary atrophy.

Fig. 5—Postoperative views following insertion of prosthesis.

In early attempts at augmentation mammaplasty, free fat transplants were used to augment the mammary tissue.[6] These, although successful in some cases, were often followed by resorption and loss of substance. The use of dermal-fat pedicle flaps was also attempted[7,8] but here again, in the woman with hypoplastic breasts, there was inadequate subcutaneous tissue to utilize in building up the breast contour. Earlier prosthetic materials such as polyvinyl ether sponge became quite firm after implantation due to the ingrowth of fibrous tissue into the prosthesis.[5]

To date the silicone rubber prosthesis devised by Cronin has given the most satisfactory results. This substance elicits little if any tissue reactivity and remains quite soft.

Technique of Operation

With the patient anesthetized under general anesthesia, the anterior chest is prepped and draped. An incision is made in the inframammary fold measuring approximately three inches in length. The incision is carried in a step-shaped fashion down to the pectoral fascia. Beneath the skin the incision is carried inferiorly creating a subcutaneous pocket of tissue. The incision is then carried directly to the pectoral fascia. The overlying subcutaneous tissue and glandular tissue is then elevated from the fascia by a combination of sharp and blunt dissection. Hemostasis is secured by the use of 4–0 plain gut ligatures. It is essential that absolute hemostatis be obtained to prevent hematoma formation. After the breast tissue has been elevated from the chest wall, the prosthesis is then carefully positioned in the pocket. The subcutaneous tissue is then approximated with 4–0 chromic catgut and the skin approximated with a subcuticular 5–0 nylon suture. The subcutaneous tongue of tissue which was created when making the incision enables a two-layer closure on different planes so that the prosthesis is not in contact with the cutaneous suture line. A large bulky compression dressing is applied to the area overlying the breasts. The patient is hospitalized for approximately two to three days. The dressing is changed on the fourth postoperative day and replaced by a smaller dressing worn inside the patient's brassiere. On the seventh postoperative day the subcuticular suture is removed and the patient is instructed to refrain from heavy exercise for approximately three weeks.

The most common complication following augmentation mammaplasty is an accumulation of serum or hematoma beneath the skin flaps. This may be prevented in most cases by meticulous hemostasis, a firm compression dressing, and by eliminating strenuous activity during the healing period. Only rarely is it necessary to aspirate the accumulated serum. The other complication which has been observed is extrusion of the prosthesis through the overlying skin. Fortu-

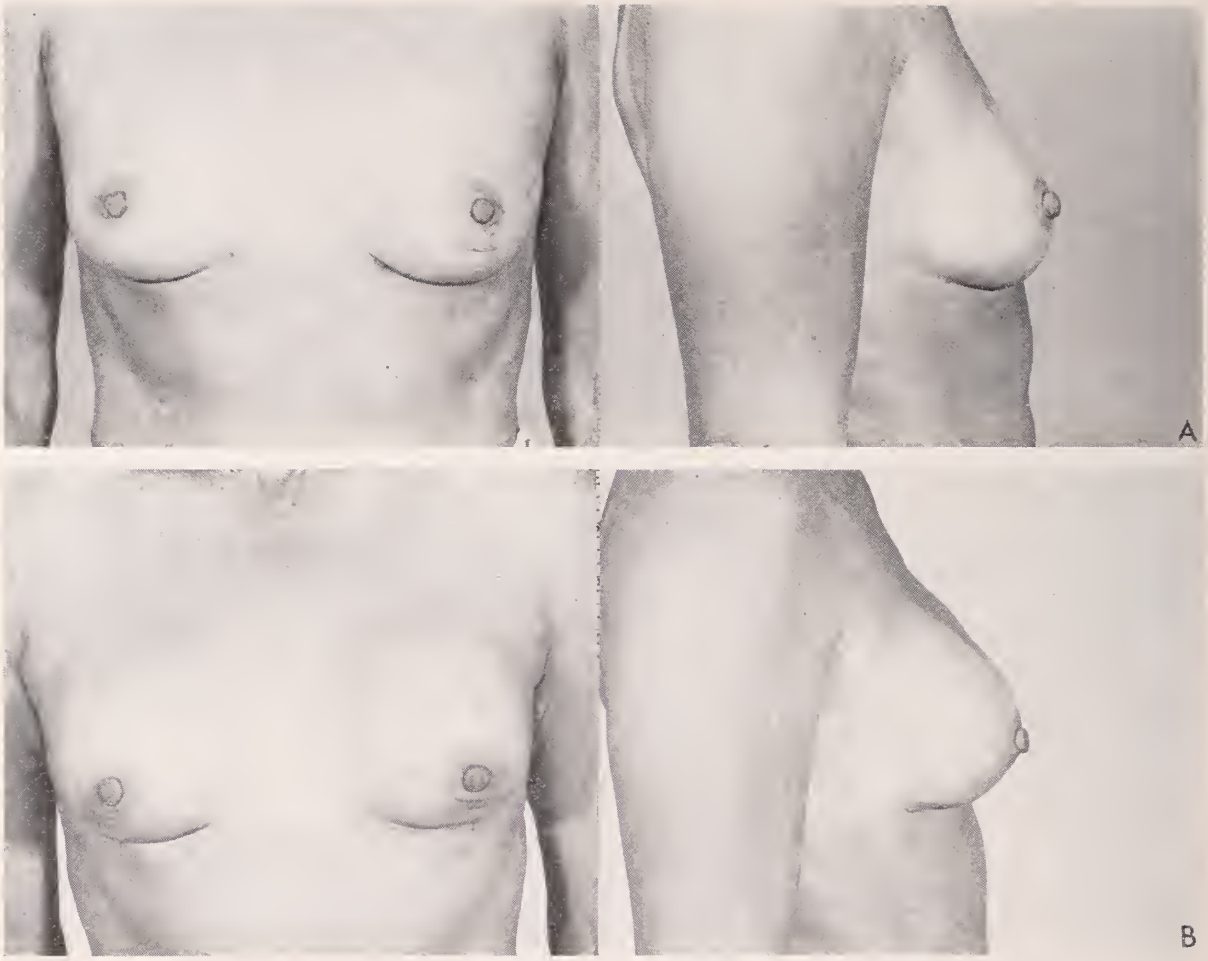

Fig. 6—A: Breasts which show scars following repeated biopsies for chronic cystic disease. *B:* Postoperative views following total subcutaneous adenectomy and insertion of breast prosthesis. C: Glandular tissue removed from above breast.

nately, this complication is exceedingly rare and can be eliminated using the tongue and groove type incision and by insuring adequate subcutaneous tissue between the flap and skin. In those instances where the prosthesis becomes exposed, the prosthesis is removed and healing is allowed to occur. Another prosthesis can usually be inserted after healing is complete. In those patients who have had multiple biopsies of the breast and who subsequently have a subcutaneous mastectomy and prosthetic replacement of the breast, one may see areas of vascular insufficiency in the overlying breast skin due to the numerous surgical procedures. In these cases there is discoloration of the skin during the healing process and irregularity of the skin surface which usually disappears with the pass-

age of time. One must recognize the need for preservation of a good subcutaneous layer of tissue when performing a simple mastectomy in order to provide an adequate blood supply to the overlying skin and an adequate coverage for the prosthesis.

The incidence of mammary carcinoma in patients who have had augmentation mammaplasty using the silicone prostheses has been no greater than that expected in the general population. In no cases has the carcinoma been related to the presence of the prostheses. Since the prosthesis is placed beneath the breast tissue, the glandular tissue is readily accessible for examination and the prosthesis in no way interferes with such examination.

Summary

Augmentation mammaplasty for treatment of the hypoplastic breasts or those breasts affected by post-partal atrophy results in a pleasing physical improvement and a significant improvement in the emotional response of the patient to her physical being.

Prosthetic replacement of the breast following subcutaneous mastectomy for benign disease has resulted in elimination of many of the psychological problems associated with the classic simple mastectomy and should be considered whenever such a procedure is indicated.

Subcutaneous mastectomy through an inframammary incision provides excellent exposure to the breast tissue, allows for complete ablation and examination of the entire glandular tissue, and allows for a radical mastectomy should one find carcinoma in the specimen.

There has been no instance of carcinoma following insertion of the prostheses which could be attributed to the presence of the prostheses. Examination of the breast is likewise not affected by the presence of the prostheses since it underlies glandular tissue and indeed, probably makes the breast tissue more accessible to examination.

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CLINICAL SPECTRUM OF PRIMARY TUBERCULOSIS IN ADULTS: CONFUSION WITH REINFECTION IN PATHOGENESIS OF CHRONIC TUBERCULOSIS

W. W. Stead et al, Milwaukee County General Hospital, Milwaukee, Wis.: *Ann. Intern. Med.* 68:731–745 (Apr) 1968

Thirty-seven adults with tuberculosis are reported, in whom there was evidence (usually tuberculin conversion) that infection was of primary type. The clinical spectrum of primary tuberculosis ranges from a total lack of symptoms in most to massive miliary tuberculosis in a few. Between these extremes, 9 were observed with minor clinical illness accompanied by parenchymal infiltrate, 11 with pleural effusion, and 16 with chronic tuberculosis. Chronic lesions appeared in some at the site of the primary implantation but were more common in the apex, probably because of hematogenous seeding there in the course of the primary infection.

Of particular interest were 16 patients in whom primary tuberculosis progressed within a few months or years into chronic pulmonary tuberculosis; reinfection appeared to play no role. Such progression supports the "unitary concept" of tuberculosis recently advocated.

Whenever tuberculin-negative persons (even adults) are exposed to an open case of tuberculosis, infection may take place and be treacherous: primary tuberculosis is difficult to recognize because of mildness of illness, tendency to spontaneous "healing," and lack of prior tuberculin data in most cases Despite absence of initial illness, primary tuberculosis may progress either sooner or later to chronic tuberculosis. Prevention of serious complication of primary infection can be accomplished by two means: vaccination of persons who must be exposed in work (Peace Corps workers, etc.) with Calmette–Guerin bacillus to prevent infection, or prophylactic chemotherapy with isoniazid (INH) for those in whom infection has already occurred.

Therapeutic Dilemmas

No. 9 of a Series

Editor:

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These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

REGIONAL ENTERITIS

Moderator: PHILIP H. SEEFELD, M.D.
Participants: A. JAMES BUTTLES, M.D.
HERBERT W. POHLE, M.D.
ROBERT W. BYRNE, M.D.
WILLIAM SCOTT, JR., M.D.
JOHN PLACE, M.D.
ROBERT R. KOENIG, M.D.

Dr. Philip H. Seefeld: This morning we are presenting a case of fascinating interest from both diagnostic and therapeutic standpoints, and are privileged to have with us for the hour Doctor William Scott, Jr., Professor of Surgery at Vanderbilt University, who as you know will spend the next few days as 9th Gunderson Visiting Professor of Surgery at Marquette University. Doctor Buttles will present the protocol of the case.

Dr. A. James Buttles (Resident in Medicine): The patient, a 54-year-old white woman, employed as a cost accountant in a local manufacturing plant, was admitted to this hospital for the first time in December 1965, with the complaint of cramps and diarrhea for the preceding three or four months and a weight loss from 132 lb to 117 lb during that period. She was tall and thin and somewhat hyperactive, but did not appear ill. Blood pressure was 120/70 mm Hg, pulse 80, oral temperature 99.6 F. Bowel sounds were hyperactive and there was an ill-defined tender mass in the midline just below the umbilicus. All the laboratory values were within essentially normal limits. The history will be developed later. During this first admission the patient responded well to rest, phenobarbital, tincture of belladonna to tolerance, a soft, milk-free diet and vitamins. She left the hospital asymptomatic after 15 days.

Dr. Seefeld: Doctor Pohle, would you care to enlarge the picture since this was your patient?

Dr. Herbert W. Pohle: We have seen a great deal of this lady through the years. She really had two distinct types of diarrhea. Her "way of life," as she called it, was habitually to have 2 or 3 loose stools after breakfast, but then to be free for the rest of the day to eat and do as she pleased without discomfort of any sort either day or night. But under any kind of stress the pattern sharply changed into one of cramps and explosive diarrhea that was severe enough at times to threaten her with inability to continue working. At night during these periods she was "filled with gas" and greatly disturbed by abdominal pain. She was a vigorous, outdoor person, who also occupied herself intellectually and was employed in an executive capacity. But the history is important. Her father's death in a "heart attack" at the age of 40 left her mother with three children, one of whom was a juvenile diabetic. The mother went back to school, earned a master's degree, and put all of the children through college, only to have the 21-year-old boy die of his diabetes. The patient and her brother, now a man of 51 years and apparently well, both became cost accountants, in their father's footsteps. The patient, who lives with her 87-year-old mother, has had several of these diarrheal upsets, including a very severe one lasting three months 10 or 12 years ago when she was adjusting to her present job, with a recurrence lasting nine months two years later, and this most recent one that appears to have been precipitated by the establishment in her office of a young male wizard with his computer paraphernalia, whose activities forced her to go to night school for emergency training and convinced her that she was now only nominally the "head" of cost-accounting. She had reached the point of feeling the position to be an intolerable one.

Figure 1

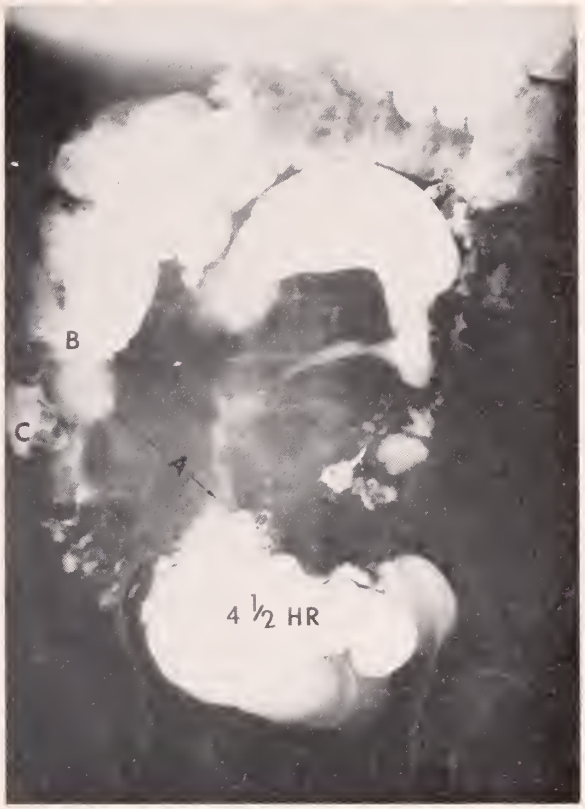

Figure 2

Since 1955 we have been constantly concerned that we might be missing something of diagnostic importance, and hence accumulated quite a sizeable x-ray folder, but not until two days prior to this hospital admission did we succeed in getting the x-ray evidence of real pathology that Doctor Byrne will demonstrate.

A Physician: I suppose there had been sigmoidoscopic examinations as well as the x-ray studies?

Dr. Pohle: Many, through the years, and always negative.

A Physician: She was discharged on a milk-free diet; why was this?

Dr. Pohle: She had experimented liberally with her diet, sometimes on her own responsibility, sometimes at our instigation. While she was in hospital it *seemed* to us, though we were far from sure because of the numerous other environmental factors, that she improved on a milk-free diet, so we discharged her on such a diet, although it had not been helpful on previous occasions. She was also receiving a combination of sedatives and antispasmodics.

Dr. Seefeld: Doctor Bryne, would you like to develop the x-ray aspects of the case now?

Dr. Robert W. Byrne: In numerous studies since 1956 we found no significant evidence of pathology until Dec. 3, 1965, two days prior to admission, when there was marked increase in transit time and, in the two-hour and 15-minute film, our first evidence of an abnormal small bowel pattern (arrow in Fig 1), probably in mid-ileum or slightly distal. From that point on (Fig 2, 4½ hr film), the abnormal small bowel seems to have a continuous loop here at (A); the ileocecal valve is probably in the region of (B). I believe the distorted cecum and ascending colon is here at (C). There is no segmentation but there are areas of dilatation and a cobblestone appearance to the mucosa in the diseased portion. You might say that there is a little skip area and more inflammatory disease in the terminal ileum. All the loops are separated and this probably represents the top of a mass lesion. At this point our diagnosis was strongly inclined toward regional enteritis, but from the history and presence of a mass we could not definitely exclude some sort of lymphoma.

Figure 3

Dr. Seefeld: Did you see any sort of "string" sign?

Dr. Byrne: No, but I should like to show a film (Fig 3) made 15 days later because there is a change in the appearance of the diseased area, an improvement over the findings in the earlier film.

A Physician: Had the patient had corticosteroids?

Dr. Seefeld: Corticosteroids had not been used.

Our guest, Doctor Scott, has had extensive experience, and has greatly contributed, in the field of gastrointestinal surgery. I shall call upon him for discussion now.

Dr. William Scott, Jr.: It is a privilege to participate in a primarily medical conference with regional enteritis as the subject for discussion. With regard particularly to the therapeutic aspects of this entity, I should like to make a plea to the internists to look a little more kindly upon the suggestion of surgical intervention. Studies in the large clinics in recent years—such as those of the late Doctor John Waugh's group at the Mayo Clinic (K. W. Barber, Jr., J. M. Waugh, O. H. Beahrs and W. G. Sauer: Indications for and results of the surgical treatment of regional enteritis, *Ann. Surg.* 156:472, 1962), and Doctor Bentley Colcock and associates at the Lahey Clinic (B. P. Colcock and C. Fortin: Surgical treatment of regional enteritis: review of 85 cases, *Ann. Surg.* 161:812, 1965)—have provided evidence of remarkable success in control of the process in regional enteritis by resection of the involved bowel segment, which is usually the terminal ileum. From Doctor Waugh's report we learn that there was relief or remission of the symptoms of the disease during follow-up periods of 5 to 20 years in 80% of the individuals who had a primary resection of a localized segment of ileitis or enteritis, in whom indications for operation had been failure of improvement on prolonged medical management, obstructive symptoms, or development of enteric fistulas. And only those in the 20 percentile group came back with recurrent disease. Encouraging, too, is the fact that resection in those who had recurrence within one to five years after a primary resection successfully provided another period of relief in 75% of instances. Thus it appears that it is really only a small proportion of the afflicted people who give us such a feeling of hopelessness in the presence of this disease. The figures from the Lahey Clinic, based on resection in 350 cases, are essentially the same. Taken together, I think these two reports should cause us to give full consideration to resection in a patient such as the present one, in whom long-standing chronic disease has erupted into an acute flare-up.

Dr. Seefeld: Thank you, Doctor Scott. Now we will show you the other half of this picture, for the patient has been hospitalized again. Doctor Place, will you please present the account of the second admission?

Dr. John Place (Resident in Surgery): As has been stated, the patient was discharged asymptomatic on medical management in late December 1965. She apparently remained well until 2 A.M. on Jan. 21, 1966, when she was awakened by severe, diffuse, unremittant abdominal pain that was accompanied by chills, nausea, and several loose stools. When admitted to this hospital later in the day she had a blood pressure of 104/70 mm Hg, pulse of 100, and temperature of 102.4 F. The abdomen was distended and rigid, with generalized rebound tender-

Figure 4

Figure 5

ness and hyperresonance to percussion, hyperactive bowel sounds, and suggestion of a mass in the midline lower abdomen. She appeared to be mildly dehydrated. The hematocrit was 43%; white blood cell count, 21,700/cu mm with left shift; blood urea nitrogen, 12 mg/100 ml; venous pH, 7.47; serum amylase, 75 units/100 ml; serum electrolytes and urinalysis essentially normal.

Dr. Seefeld: Doctor Byrne will show the x-ray films from this admission.

Dr. Byrne: I am showing only the supine and upright films of the abdomen; the transverse film showed no free air under the diaphragm. Here is a (Fig 4) step-ladder configuration, probably due to obstruction, although a considerable amount of fluid obscures the loops somewhat. The distance between the gas pattern is from one loop to another and is slightly increased, suggesting either a considerable edema of the walls of the bowel itself or the presence of a small amount of peritoneal fluid. The upright film (Fig 5) clinches the diagnosis of dynamic loops. While there is probably an element of adynamic ileus here, the picture is really one of ileus combined with small bowel obstruction.

Dr. Place (resuming): Treatment was with intravenous fluids, penicillin and chloramphenicol (Chloromycetin), and a long tube was introduced; decompression with the latter was unsuccessful because the patient, being somewhat disoriented, pulled it out several times. The leukocytosis, fever, and abdominal findings persisting, exploratory laparotomy was done after 18 hours. On entering the abdomen a large amount of straw-colored fluid was encountered and the omentum was seen to be covering the viscera in the lower quadrant. Tremendously inflamed, thickened, and adherent loops of terminal ileum and mesentery filled the pelvis. This snarl of inflamed terminal ileum loops lay just distal to markedly dilated proximal ileum. The mass, a segment about 30 inches long, was mobilized and excised from 8 inches proximal to the area of diseased ileum to the middle of the ascending colon, with end-to-end anastomosis. The patient did well postoperatively except for a wound-infection on the 7th day, which yielded to compresses

Figure 6

Figure 7

and drainage, and a fecal fistula that closed spontaneously in two weeks. She was discharged on the 18th day, doing quite well with one to three non-watery stools daily.

Dr. Seefeld: Thank you, Doctor Place. So, then, we have a patient who, almost exactly one month after discharge in good condition under medical management, was back again as a surgical problem. When I saw her after admission I felt that if there had been a perforation it was localizing and that we were not dealing with generalized peritonitis. So we passed a long tube in the effort to decompress her and provide time for administration of electrolytes and antibiotics before operation. We had the tube down pretty well, perhaps to the ligament of Treitz, but as Doctor Place has related, we couldn't keep it there. By the following morning the distention had increased, and we felt surgical intervention was indicated. It is my feeling that if we cannot achieve effective intestinal decompression with the long tube in 24 hours, it is time to operate.

On exploration we found this large mass (Fig 6) of inflamed small bowel and omentum tightly lodged down in the pelvis. The involved area extended about 30 inches up into the distal ileum from the ileocecal valve, but the cecum itself was not involved. Adherence to the bladder wall had taken place at one site but there was no frank perforation. Since short-circuiting of any type would have been impossible, we did the resection and anastomosis that Doctor Place has described.

Doctor Koenig will discuss the tissue laboratory findings.

Dr. Robert R. Koenig: The first photograph (Fig 7) shows the thickening—to about 1.5 cm—of the wall of the involved portion of the intestine. The mucosa had a cobblestone appearance and contained multiple longitudinal ulcers measuring up to 3 cm. The next picture (Fig 8) is of one of the larger ulcers. Microscopically there were the typical changes of regional ileitis: ulceration of the mucosa, severe edema, and congestion of the submucosa and the subserosa, with numerous lymphocytic infiltrates and dilatation of lymphatic channels. Even the mesentery showed these changes in this case, and there were a few enlarged lymph nodes, which showed lymphoid hyperplasia and some granulomatous reaction.

Figure 8

Dr. Seefeld: I shall interrupt here for a moment. We felt good about this resection because we thought we had gotten pretty well around the involved area and had a

patient in the age group in which at least the better long-term results are to be expected. But then Doctor Koenig gave us a shock.

Dr. Koenig (resuming): When studying routine sections from the large ulcerated area where the bowel had adhered to the bladder wall we found a tumor consisting of solid sheets of pleomorphic round cells that showed numerous atypical and typical mitotic figures; and a reticulum stain showed considerable production of reticulum, so that we were justified in diagnosing a reticulum cell sarcoma. The next slide (Fig 9) shows the pleomorphic, hyperchromic tumor cells with indented nuclei and numerous nucleoli. Thus we have here two coexisting pathological entities: regional enteritis and reticulum cell sarcoma.

Dr. Seefeld: Thank you, Doctor Koenig. So our optimism for the outcome in this case has been considerably dampened. However, I will remind you that the surgery was done 14 or 15 months ago and so far no problems have arisen. The superimposition of malignant tumor on regional enteritis is uncommon but by no means a great rarity. Doctor Scott is entirely at home in this field, and I shall ask him to discuss it. Particularly we would like to know what he would have done in the situation. There was one lymph node involved in the mesentery. But we have done nothing more, shunning both more surgery and x-ray therapy; so far, we are winning.

Dr. Scott: This is a most instructive and fascinating finding. I really have no idea what the prognosis is. I think you did the right thing and that I, too, would not have considered reoperation. The resection was radical and probably comprised all you would have done had you known of the malignant lesion at the time. I think that many of us have grown up with the idea that the lymphoid tumors, the lymphosarcomas and reticulum cell sarcomas, in the gastrointestinal tract behave differently than they do elsewhere; that there tends to be a localizing factor at work there. And some of our radiologic colleagues feel that the addition of radiation therapy is in order when one finds such a lesion in resection. But not all radiologists share this view by any means; for 10 years I pled with the late Doctor Herb Francis, at Johns Hopkins, to treat people with lymphosarcoma of the gastrointestinal tract following our resections, but

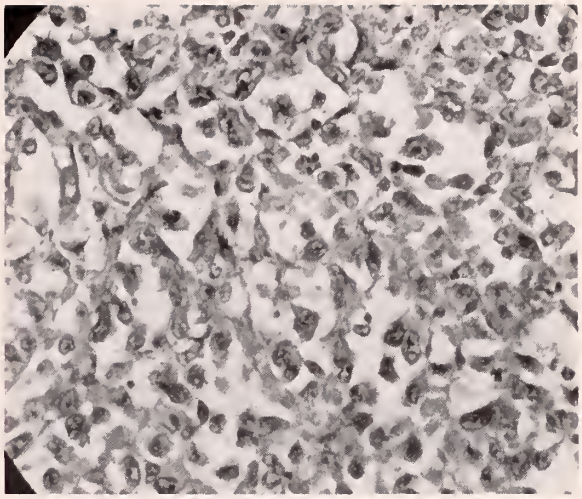

Figure 9

he simply would not do so unless we could show positive nodes or that we had done an inadequate resection. Actually I am not sure that there is much difference in the follow-up results whether there has been radiation therapy or not, but I prefer to have it if I can get the radiologist to agree. I shall be interested to hear Doctor Byrne's views.

A point of interest is whether the occurrence of reticulum cell sarcoma in chronic regional enteritis is analogous to the development of carcinoma in long-standing ulcerative colitis. If it is, then we need to be seriously thinking about planned resections in individuals who have chronic diseases of this kind. At the Mayo Clinic, the surgical pathologist, Doctor Malcolm Dockerty, feels so strongly about the incidence of carcinoma in long-standing ulcerative colitis that he would have anyone with the disease of 10 or 12 years duration submit to elective colectomy no matter how well he may have been doing clinically. Of course the result of surgical efforts in *established* carcinoma in ulcerative colitis is dismal.

Dr. Byrne: I too feel, Doctor Scott, that the lymphomas, lympho- or reticulum cell sarcoma, behave differently in the abdomen than elsewhere. We had every reason in the present case to believe that the lesion might have been localized and had been completely removed. This was a reason for not wanting to treat at that time. Another reason was that we lacked complete assurance that all the inflammatory disease had been removed.

A Physician: What kind of regimen should be prescribed in the follow-up of these people who have been resected?

Dr. Scott: I am sure there is a great deal of variation in the various clinics. Currently we are reviewing our own experience in about 50 cases. There has been no specific dietary management in this group and most of the patients have not been put on steroids, either in the early postoperative period or chronically. But Doctor Gene Bricker recently visited us and said he felt that steroids should be used in the early postoperative period. The subject is certainly controversial and I do not believe an answer will be easily found.

A Physician: Doctor Scott, had you seen this patient prior to admission would you have gone along with conservative management for awhile, as was done, to see what would happen?

Dr. Scott: Yes, before Doctor Waugh produced his remarkable statistical findings I think I would have been inclined to do so. But I now wonder whether this is the proper attitude, or whether it is not preferable to do an early resection of the diseased bowel. Of course most surgeons have been reluctant to undertake early surgery because there is not much you can do when you encounter diffuse disease. But actually this is the much less common form of regional enteritis; most patients have relatively localized lesions that can be resected. Usually if one has done a right hemicolectomy the colon distal to the anastomosis is quite normal; the disease is usually in the ileum proximal to the line of resection. I have no idea how far one should go, and I do not think Doctor Colcock has either, but he has recently suggested that we should routinely resect more apparently normal bowel than has heretofore been customary.

Dr. Seefeld (summarizing): We have considered this morning a case of regional enteritis of perhaps many years duration before an acute flare-up firmly established the diagnosis. Three weeks of hospitalization on conservative medical treatment enabled the patient to be discharged asymptomatically, but she was readmitted after one month for emergency surgery. After resection of the large mass of diseased ileum and ample nondiseased colon, she was discharged in asymptomatic condition again; but the pathological report revealed the presence of a small reticulum cell sarcoma in one area of the resected ileum. All implications of the situation were discussed.

SEROLOGIC EVIDENCE FOR HUMAN INFECTION WITH ADENOVIRUS-ASSOCIATED VIRUSES

NEIL R. BLACKLOW, (National Cancer Institute, Bethesda, Md.), M. DAVID HOGGAN and WALLACE P. ROWE: *J. Nat. Cancer Inst.* 40:319–327 (Feb) 1968.

The adenovirus-associated viruses (AAV) are a newly recognized group of defective viruses that are capable of multiplying only in cell cultures infected with an adenovirus. Their natural history is unknown, since they have been identified only as contaminants of laboratory stocks of adenoviruses. This report describes the detection of antibodies to AAV serotypes 1, 2, and 3 in human sera by neutralization, complement fixation, and immunofluorescence tests. The curve of antibody frequency showed a steep rise between the ages of 1 and 10; about one-half of older children and adults showed antibodies to one or more AAV serotypes. AAV seroconversions were demonstrated by neutralizing and/or CF antibody in 5 of 12 children residing in a receiving home for young children in 1957–58 and in 7 of 28 children residing there in 1965–66. These findings therefore strongly indicate that man is naturally infected with viruses of the AAV group. Captive African green monkeys frequently showed antibody to AAV 4. Antibodies to all 4 AAV serotypes were found in a low proportion of captive but not in wild rhesus monkeys.

SURGICAL IMPLICATIONS OF SALMONELLOSIS

WILLIAM J. SCHULTE, MD and KENNETH R. TUCKER, MD, Milwaukee, Wis.: *Arch. Surg.* 96:593–598 (Apr) 1968

During the past decade, the incidence of typhoid fever has steadily declined. In contrast to this, the rate of paratyphoid infections has increased fourfold. The majority of these infections are of the gastrointestinal tract but we have recently encountered some unusual manifestations of this disease. From Jan. 1, 1960, to Dec. 31, 1966, 83 cases of salmonellosis were treated at our institution. Eleven per cent of these cases had infections that required surgery. This group of patients all had a preexisting lesion which appeared to act as a nidus for the localization of the Salmonella organism. Another significant group of patients presented with acute abdominal pain and tenderness that were occasionally of such severity that laparotomy was performed for peritonitis that simulated a perforated viscus. A more detailed discussion of the symptoms, physical findings, and management will be presented in this most unusual and perplexing group of patients.

From Wood Veterans Hospital and Milwaukee County General Hospital, Division of Surgery, Marquette School of Medicine, Milwaukee.

Paper read before the 75th annual meeting of the Western Surgical Association, Los Angeles, Nov. 17, 1967.

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Morquette School of Medicine, Milwoukee, ond the Department of Medicine, University of Wisconsin Medicol School, Madison

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Oral Hypoglycemic Compounds

By JOSEPH A. GLENNON, M.D.
Madison, Wisconsin

■ THE SULFONYLUREAS and the biguanide phenformins are the oral hypoglycemic agents currently available. These compounds along with their dose and duration of action are listed in Table 1.

TABLE 1—*Oral Hypoglycemic Compounds*

	Trade Name	Usual Daily Dose (Grams)	Maximum Daily Dose (Grams)	Duration of Action (Hours)
Sulfonylureas				
Tolbutamide	Orinase	0.5–3.0	2.0–3.0	6–12
Chlorpropamide	Diabinese	0.1–0.5	0.5	Up to 60
Acetohexamide	Dymelor	0.25–1.5	1.5	12–24
Tolazamide	Tolinase	0.1–0.25	1.0	12–24
Biguanide				
Phenformin	DBI	0.05–0.2	0.2	4–6
Phenformin (long acting)	DBI-TD	0.05–0.2	0.2	8–12

Dietary management plays an important part in the therapy of patients selected for treatment with any of the oral agents. Obese subjects could probably be as well controlled with weight reduction as with oral therapy but long-term success with weight-reduction programs has been disappointing.

Mode of Action

The primary action of the sulfonylureas appears to be stimulation of endogenous production of insulin by the pancreas. That of phenformin is not well understood but is thought to be promotion of the anerobic metabolism of glucose.

Doctor Glennon is Assistant Professor of Medicine, University of Wisconsin Medical Center.

Selection of Patients

Patient selection is essential in determining the outcome of primary oral hypoglycemic therapy. The best candidates are diabetics whose disorder appeared after 40 years of age (adult-onset diabetics), is of recent occurrence, stable resisting ketosis, and controlled with small doses of insulin.

Effectiveness of Therapy

Successful diabetic control with an oral agent must be judged according to criteria selected by the individual physician. Using the rigid criteria of the Joslin Clinic,[1] to measure success, approximately 60% of properly selected adult-onset diabetics may be adequately controlled with a sulfonylurea. Primary success is judged after a period of at least one month of satisfactory blood sugar control. Following primary success no more than 5% to 10% of patients will become true secondary failures.[2] Of these secondary failures approximately 20% will be successfully controlled with a different sulfonylurea.

Special Applications

Phenformin, has little lipogenetic effect as evidenced clinically by a modest weight loss in obese diabetic patients. For this reason it has been advocated instead of the sulfonylureas in the treatment of this type of diabetic. Effective long-term weight reduction with phenformin has not been reported as yet.

Phenformin has also been used as an adjunct to insulin in an attempt to smooth out control in brittle juvenile diabetics. The use of sulfonylureas along with insulin, for this purpose, has been ineffective.

The combination of phenformin and a sulfonylurea has been proposed in patients imperfectly controlled with either agent alone.

It has been reported that 70% of those treated with this combination will be adequately controlled.[3]

Dosage

Initial loading doses formerly suggested with the sulfonylureas are no longer used. Doses above the maximum daily dose listed in the table lead more often to toxicity than to therapeutic success. Treatment with any of the agents is begun with the smallest dose and adjusted upward depending upon the patient's response to a given dose.

Tolbutamide is usually administered in divided doses, chlorpropamide as a single daily dose and the other agents as single or divided doses depending upon the total dose required for control. Divided doses become necessary as the total dose required for control becomes larger.

Adverse Reactions

Toxic reactions to the sulfonylureas take place in less than 5% of the patients treated with them. Dermatologic, hematologic, neurologic, and gastrointestinal disturbances account for most of the complications encountered.[4] Hypoglycemic reactions to the sulfonylureas are infrequent and chiefly restricted to the elderly or debilitated patient. The duration of the hypoglycemia induced varies with the compound used and is most prolonged with chlorpropamide.

Serious toxicity to phenformin has not been documented although several reports have suggested it as a cause of fatal lactic acidosis. Metallic taste, nausea, anorexia, vomiting, diarrhea, or cramps are the most frequent adverse reactions experienced with phenformin and to a degree are dose dependent. These side effects have been diminished since the introduction of long-acting phenformin.

Stress and Insulin

Infection, major surgery, and at times other forms of stress may require the substitution of insulin for one of the oral agents even though control with the oral agent under ordinary circumstances is perfectly adequate.

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CARDIOPULMONARY RESUSCITATION AT UNIVERSITY OF WISCONSIN

John R. Benfield, MD and Robert C. Hickey, MD, Dept. of Surgery, University of Wisconsin: *Arch. Surg.* 96:664-670 (Apr) 1968

The organization of cardiopulmonary resuscitation efforts at the University of Wisconsin was described. During an 18-month experience with this program, 94 recorded calls for the resuscitation team included 84 resuscitative attempts of which 36% were initially successful. One-third of the patients who were initially revived, or 12% of those who had any resuscitative efforts, left the hospital alive. The underlying diseases from which the patients requiring resuscitation suffered were as follows: cardiovascular, 44%; neoplastic, 22%; respiratory, 8%; traumatic and hemorrhagic, 8%; and inflammatory or miscellaneous benign disease, 7%. The primary disease in the remaining 11% of the patients is unknown because their resuscitation records did not contain this information.

The resuscitation cart and team were neither intended for use in intensive care areas nor were they frequently utilized in such units. The program is aimed at serving nursing units which are equipped in an average fashion, and the authors have aimed at educating average nursing personnel to undertake interim resuscitative measures while awaiting the team. The need for continuing educational programs teaching resuscitative techniques, including a plan of action and a sound philosophy, was stressed.

Read before the 75th annual meeting of the Western Surgical Association, Los Angeles, Nov. 17, 1967. Doctor Benfield is now at Harbor General Hospital, Torrance, Calif., and the Department of Surgery, University of California at Los Angeles, Los Angeles. Doctor Hickey is now at M.D. Anderson Hospital, Houston, Tex.

BOOKLET: CLASSIFICATION IN PSYCHIATRY AND PSYCHOPATHOLOGY

A broad, in-depth discussion of the issues related to the classification of mental disorders is presented in *The Role and Methodology of Classification in Psychiatry and Psychopathology*, a new U. S. Public Health Service publication.

The 590-page volume is PHS Publication No. 1584, available from the Superintendent of Documents, U. S. Government Printing Office, at $4.50 a copy.

W. D. James, M.D.

PRESIDENT'S PAGE

Have a Complaint? See Your Grievance Committee

THE MEDICAL PROFESSION has always taken pride in its ability and willingness to regulate and discipline itself. There is built into the structure of our professional organization the machinery for correcting any unprofessional or unethical practices which may occasionally occur.

Most county medical societies have a grievance committee, and there is also such a committee at the state level. Any person, physician or otherwise, who has a complaint against any one of our members is urged to file documented evidence with the grievance committee of his county medical society. All such charges will be reviewed and proper action taken. In the event that action at the state level is needed, it will be referred to the grievance committee of the State Medical Society.

Physicians of Wisconsin have recently been castigated in the news media as the result of charges by a member of our own profession accusing us of opportunistic profiteering in our dealings with Medicare and Medicaid patients. If there is documented evidence to support these charges, it should have been properly presented to the grievance committee of the county medical society and not to the news media. The latter procedure can only undermine public confidence in the medical profession, since it seems to indict all physicians for the sins of a very few.

The State Medical Society is proud of its members and believes in their honesty, integrity, and professional ability. We have both the procedural means and the earnest desire to deal with problems such as the charges recently made, and we shall attempt to do so without resorting to newspaper headlines.

W. D. James M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

JULY 1968

Vol. 67 No. 7

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Editor's Note: *Once in a great while a piece of writing comes along, such as the following guest editorial, for which no word seems adequate except transcendental. When Dr. Leslie G. Kindschi reviewed the article on coronary atherosclerosis in this issue, he commented on the danger of engrossment in statistical correlations, and was invited to write an editorial on the subject. Lord, how it needed saying. His brilliant exposition should be read many times by every physician.*
—D.N.G.

GUEST EDITORIAL

Paradox and Perspective in the Practice of Medicine

A PARADOX is a proposition that is valid in terms of strict logic, but absurd in terms of experience and common sense.

The classic example was proposed by the ancient Greek, Zenno, who, by using strict Greek logic, "proved" that the fleet footed Achilles could not possibly win a race with a slow moving tortoise, if the tortoise were given any head start at all.

This is absurd, of course. But it is just another way of saying that theory does not always work out in practice, or that every rule (including this one) has its exceptions. It is the recognition of these exceptions that brings the quality of perspective into the process of reasoning.

The modern practitioner of medicine can define many parallels in his day to day experience. Much of what he does is based on theory, and many of his decisions are based on statistical odds. This is the logic that guides him, but it too can also trap him in paradoxes if he regards logic as infallible, or if he loses his ability to distinguish between the worlds of fantasy, possibility, probability, and actuality.

The most precise area of medical science lies in the field of infectious disease. Dominated by the rigid discipline of Koch's Postulates, abstract theories gradually acquired the substance of facts. Even when a paradox appeared, as happened when it became evident that many people exposed to tuberculosis did not develop the clinical disease, resolution was possible when the factors of quantitative exposure and the genetic variables of host resistance were defined.

It must be noted that in the field of infectious disease we were dealing with a single etiologic agent in the environment, and that the biological response of the host was consistent enough to minimize the role of genetic variables in the equation.

But in the fields of neoplastic, metabolic, degenerative, and mental disease, the problems are entirely different, and infinitely more complex. We have been unable to define the single environmental etiologic agent according to Koch's Postulates, and we are constantly finding major genetic variables about which we know little or nothing.

Since Koch's Postulates do not seem to apply, we have substituted the discipline of statistics, in particular, the discipline of statistical correlation. But the difference is only a matter of degree. Koch's Postulates require a 100% statistical correlation as proof, whereas modern thinking seems to be satisfied with considerably less, providing, of course, that the correlation is "statistically significant," whatever that may mean.

But no matter how you slice it, anything less than 100% correlation is still in the category of evidence rather than in the category of proof. And evidence can be circumstantial, and deceptive.

Thus we run the risk of being trapped in a paradox whenever we begin to blur the essential distinction between evidence and proof. The risk is particularly great when the evidence provided by a mass of "significant statistical correlation" is lifted out of its essential context, given the mantle of truth (by implication at least), and used as the basis for a crusade.

Statistical method is undoubtedly the predominant discipline in modern clinical research. But it always poses a challenge to intellectual integrity. We can meet this challenge only by maintaining a proper intellectual perspective. Otherwise we may well become lost in a maze of cumulative paradoxes from which there is no escape.

—LESLIE G. KINDSCHI, M.D., Monroe

E. J. NORDBY, M.D.

Deep Footprints

RECORDS OF THE State Medical Society of Wisconsin show that the position of Chairman of the Council was created in 1903, at the time of the reorganization of the State Society. W. T. Sarles of Sparta was the first chairman and served until 1906. For the years 1907 and 1908, E. L. Boothby of Hammond was chairman.

Edward Evans of La Crosse served as chairman from 1909 to 1928. In 1929 Arthur W. Rogers of Oconomowoc became chairman, followed by S. E. Gavin of Fond du Lac, 1937 through 1948, R. G. Arveson of Frederic, 1949 through 1958, and James C. Fox of La Crosse, 1959 into 1968.

These men recorded notable efforts in the affairs of the Society. Their contributions were unselfish and dedicated to public health and their profession. Their footprints are indeed deep.

In May, E. J. Nordby, M.D., of Madison succeeded to this high office. Our best wishes are extended to him in confidence that he will follow in the finest traditions of his predecessors.

Invest in the future health of the nation and your profession

AMA-ERF Give to medical education through AMA-ERF

AMERICAN MEDICAL ASSOCIATION
EDUCATION AND RESEARCH FOUNDATION

535 N. Dearborn St.
Chicago 10, Ill.

Are We Well Fed?

WE DON'T APPEAR to be applying our material and intellectual resources as well as we might to solve the solvable nutrition problems that face too many children and adults and elderly and poor in our country. It's time to reexamine some of the goals of nutrition research in America.

There is so much talk these days about overpopulation and starvation elsewhere in the world that it is easy to lose sight of the fact all is not well right here at home. When it comes to setting priorities for our talents, we as "haves" are all too often made to feel guilty about the lot of the "have nots" by declaring that since we have such an abundance of food, there is little or no malnutrition in the United States. Every time a ship sails from an American port, laden with grain to fill the mouths of the hungry in some impoverished land, there is a little less inclination to accept the idea that there may very well be malnutrition within our own borders that we could do something about.

If we are honest with ourselves, we will admit there is at least the possibility that too many Americans are not well fed at all. Dr. William H. Stewart, the Surgeon General of the U.S. Public Health Service, in testifying before a Senate committee pointed out that while we had been able to conduct nutrition surveys all over the world, "We do not know the extent of malnutrition anywhere in the United States."

Talk to any grade-school teacher or a perceptive school nurse. Ask them about the number of pretty little six-, seven- and eight-year-olds who trudge to school each morning without breakfast. You will certainly be alarmed at the answer you get. Here is a budding nutrition problem that borders on the scandalous. What is the meaning of this lack of what nearly everyone regards as the most essential meal of the day for these little children who are still growing and who are struggling to learn? What does this do to their ability to learn? What does it do to their present and future health? What can be done about it? Who knows?

One of the best organized studies on the nutritional status of our teenagers has now expired at midpoint, starved from the lack of the two vital foods: motivation and money. Yet what is the nutritional status of our young people? We know that they are undergoing the most stressful period of their lives. We know their food demands are tremendous, and we know they develop all sorts of faulty eating habits. How well nourished are these young children in America? They look healthy. So do the Watusi. But, are our youngsters indeed well nourished? Who knows?

Middle-age obesity is said to be the major illness in our land today. That the clinicians who see obese patients need the help of the nutritionist is evident from the fact that the practicing physicians' record in trying to get a firm grasp on this nettle is less than enviable. Because clinicians don't seem to be able to cope with obesity and it has not been given the attention in research that a national disease deserves, the quacks and the charlatans have moved in. What can be done about obesity? Who knows?

A little over a year ago, the American people made a commitment to pay for the medical care of our elderly citizens. It is, therefore, surprising to find that the list of grants for research this year reveals little curiosity about the nutritional problems of the elderly. Is there anything we know about nutrition that would return some of them to productivity and brighten their remaining years? Who knows?

It is generally accepted that poverty and undernourishment are bedfellows. The economists know where to find the poverty, but can we spot the undernourishment? Considering this parallel, malnutrition is undoubtedly prevalent in Appalachia, in our slums and in certain rural areas. It's not hard to imagine that there are enough interesting problems in these places to whet the intellectual appetites of a small army of nutritionists. But is anybody shipping "Incaparina" to Harlem? What is the effect of this undernourishment on these people, on our economy, on our society? Is it this that freezes them into the hard core of unemployables that so vexes our social planners? To what extent is nutritional status to blame for the predicament of the poor, seemingly uneducable Negro whose plight in this land of plenty is offensive to Christian decency? Who knows?

These are some of the problems that exist here in our own backyard. They cry out for recognition and solution.—Reprinted, in part, from NUTRITION TODAY, March 1968, written by the editor, Cortez F. Enloe, Jr., M.D.

LETTERS

OPPORTUNITIES WITH PEACE CORPS

To DOCTOR KIEF:

I am greatly concerned that too few of our physicians are aware of the opportunities available with the Peace Corps. The enclosed brochure describes some of the problems and opportunities faced by staff physicians. The experiences have been invaluable for the individual physicians as is evident in Dr. Joseph's article and those of the other staff physicians. (Brochure available upon request to the State Medical Society, Box 1109, Madison, Wis. 53701.)

There is no doubt that as we increase our efforts to work cooperatively with developing countries, as we begin to deal more effectively with our own poverty-associated health problems, and as we enlarge the career opportunities in these areas, the Peace Corps will become an increasingly important stepping-stone to a variety of career opportunities.

Beyond this there is the remarkable and important job the Peace Corps Volunteers are doing to make America's commitments to developing countries come alive. It is vital that American medicine not let the Peace Corps Volunteers down. There is urgent need for staff physicians, this July, to fill the vacancies which can no longer be filled by Public Health Service physicians meeting their military obligations.

I will appreciate your making this information available to all of the members of your State Society.

Please write to me or to Dr. Stanley Scheyer, Director, Office of Medical Programs, Peace Corps, Washington, D. C. 20525, for additional information.

PHILIP R. LEE, M.D.
Assistant Secretary for Health and Scientific Affairs
Department of Health, Education and Welfare
Washington, D. C. 20201

URGES REGISTRATION OF HEMOPHILIACS

TO THE EDITOR:

One of the chief reasons for the existence of the Wisconsin Chapter of the National Hemophilia Foundation is to help the victims of hemophilia in the area we serve. Although our office is in Milwaukee, this Chapter is the only agency devoted exclusively to hemophilia to which sufferers and their families, in the entire state of Wisconsin, may turn to for aid.

But—unless we know who these people are and where they live, we cannot be of much assistance.

Some physicians have estimated that only a small percentage of the hemophiliacs in Wisconsin are registered with the Chapter.

We are calling on you for help in the case-finding program which is being conducted by the Gertrude Burghardt Auxiliary for the Wisconsin Chapter.

The enclosed leaflets are intended for your information and for your files. If you know of ways in which you can use the "Help Register All Hemophilia Sufferers" leaflet, we shall be happy to supply such quantity as you request.

Any cooperation you can give towards helping us to develop a more complete record of the victims of hemophilia in your community will be deeply appreciated by us and of immeasurable help to them.

(MRS.) SHIRLEY GROESCHEL, *President*
Gertrude Burghardt Auxiliary
Wisconsin Chapter
National Hemophilia Foundation
5214 N. 63rd Street
Milwaukee, Wis. 53218

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

HEART ASSOCIATION INVITES RESEARCH SUPPORT APPLICATIONS

Research investigators may now apply to the American Heart Association for support of studies to be conducted during the fiscal year beginning July 1, 1969. Sept. 15, 1968, is the deadline for submitting applications for Established Investigators, Foreign Visiting Scientists and British–American Research Fellowships. Applications in the Grants-in-Aid category are due by Nov. 1, 1968.

Awards in 1969–70 will be made in the following categories: established investigatorships, foreign visiting scientists, and British–American research fellowships.

Application forms for investigatorships and fellowships may be obtained from the Director of Research, American Heart Association, 44 East 23rd Street, New York, N. Y. 10010.

THE MEDICAL STUDENT FORUM

Devoted to the expressions of the medical students at the University of Wisconsin and Marquette medical schools through association with the Student American Medical Association. A feature originated by the State Medical Society of Wisconsin to stimulate closer relationships with the physicians of tomorrow. This space is offered monthly to both schools on an alternating basis, with copy deadline the first of the month preceding the month of publication. Statements and opinions contained herein are those of the students.

JULY 1968

RECENTLY, A SURVEY of senior medical students was made to determine what characteristics were considered desirable in an internship. Questions were asked about types, locations, university affiliation, variety of medicine practiced, and remuneration. Some of the results follow.

In answer to the question, "To what part of the country would you prefer to go?" the following responses were obtained:

	Far West	Midwest	East
North	30%	0%	1%
South	59%	1%	9%

FAR WEST PREFERRED INTERNSHIP

To define the far West's apparent appeal for future medical men, we asked the students the reasons for their choices. Most frequently cited were: "It's the farthest distance from home," "congenial political climate," "attractive flora" (common for those choosing South), "unusual fauna" (common from those preferring North), and "easy access to taco stands."

To determine the effect on students of medical school training, with its academic atmosphere so close to the private practice of medicine, we asked our subjects to list the hospital interviews they had had during the first three weeks in June. Analysis of the 473 hospitals revealed that 37 were university affiliated and 436 had no affiliation whatsoever.

Especially with University of Wisconsin Hospitals training in the back of our minds, we asked whether students preferred an internship with chronic illness or acute medicine predominating. The result was expected:

100% acute
0% chronic.

Some of the reasons? "I'd like to see a patient who hasn't published his history so that he can hand it to every new M.D. he sees." "I wish I had a chance to make a differential diagnosis instead of getting it as a chief complaint." "The opportunity to make the first mistake with a patient is sacred; but with the patients I get, I have to sit up all night to even think of a new mistake."

Another important question related to money and its role in the selection of internships brought out the following response:

7%—most important factor
47%—secondary, but must be reasonable
41%—subsistence all that's necessary
5 %—unimportant; don't even consider it.

MONEY SECONDARY INTERNSHIP

A representative explanatory comment on this question by a member of the "subsistence" group was, "I feel that the type of experience gained during internship is much more important than the amount of money involved. My wife and I have agreed that for a really top-notch position, say at Massachusetts General Hospital, we could get along for one year on as little as $6,000 with full maintenance. That is, if she works too, of course." The "unimportant" group was referred for psychiatric counseling.

In answer to our final question, "Will you be taking a rotating or a straight internship?",

72% responded "yes,"
23% responded "no,"
5% were undecided.

When further questioning revealed that of those answering "no," the preference as to type of internship was:

39% high-pay type,
14% no-night-call type,
47% excellent-climate type,

and we decided to forget the whole thing.—RICHARD CHRISTENSON, SAMA, University of Wisconsin, Madison.

MINUTES OF COUNCIL MEETING

MILWAUKEE, MAY 12, 1968

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:00 p.m. on Sunday, May 12, 1968, at the Sheraton–Schroeder Hotel in Milwaukee.

All voting members were present: Doctors Bayley, Schulz, Nordby, Stoops, Huth, Carey, McRoberts, Sisk, Dettmann, Fox, Boren, Ludwig, Manz, Grand, Egan, Sullivan, Houghton, Van Hecke, Chojnacki, Hollenbeck, Wright, Past President Drew, President Kief, and Speaker Behnke.

Officers and others present: President-elect James; Treasurer Weston; Doctors Bell, Bernhart, Galasinski, Hildebrand, Picard, and Hill, AMA delegates and alternates; Doctor Simenstad, AMA trustee; Doctors Hilliard and Stahmer, reference committee chairmen; Doctor Gundersen; Messrs. Crownhart, Thayer, Koenig, Brower, Reynolds, Salt, Maroney, Waldschmidt, Tiffany, Gill, White, Murphy, Kluwin, Weise, Mrs. Anderson and Miss Pyre.

2. Minutes of March 9–10, 1968

On motions by Doctor Sullivan, seconded and carried, the following three additions were made to the minutes of March 9–10, 1968:

A. Item 4. A. 5. Section 7, Principles of Medical Ethics of the American Medical Association: In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

B. Item 4. E. If this (National Blue Shield equalization) agreement were not signed, WPS could not participate in national account enrollments.

C. Item 6. It was the feeling of the Council that in the future questionable (guest) editorials or letters should appear as letters to the Editor.

On motion of Doctors Chojnacki–Schulz, carried, the minutes were approved as amended.

3. Commission on State Departments Elections

By separate motion duly made, seconded and carried, the following were elected for the ensuing year:

T. W. Tormey, Jr., M.D., Madison, general chairman

W. J. Egan, M.D., Milwaukee, vice-chairman

Division chairmen:

G. G. Stebbins, M.D., Madison, Aging (deceased at this printing)

D. A. Treffert, M.D., Fond du Lac, Alcoholism and Addiction

H. A. Anderson, M.D., Stevens Point, Chest Diseases

Meyer S. Fox, M.D., Milwaukee, Ear, Nose and Throat

John J. Suits, M.D., Marshfield, Handicapped Children

John R. Evrard, M.D., Milwaukee, Maternal and Child Welfare

E. E. Houfek, M.D., Sheboygan, Nervous and Mental Diseases

P. A. Dudenhoefer, M.D., Elm Grove, Rehabilitation

J. C. H. Russell, M.D., Fort Atkinson, School Health

J. V. Bolger, Jr., M.D., Waukesha, Vision

4. Annual Report of Treasurer

Doctor Weston distributed and discussed his annual report on the general fund of the Society.

On motion of Doctors Ludwig–Grand, carried, the report was accepted and transmitted to the House of Delegates.

5. Resolution by the Section on Pathology

On motion of Doctors Van Hecke–Bayley, carried, the Council endorsed Resolution J which was introduced to the House of Delegates in response to the Council's earlier referral to the Section on Pathology of the problem with Medicare presented by the Consultant Physicians in Pathology of Beaver Dam.

6. Late Resolutions

By separate motions duly made, seconded and carried, three resolutions submitted after the deadline specified in the bylaws were forwarded to the House of Delegates with approval of the Council:

A. By Clark County Medical Society on the shortage of nurses

B. By Seventh Councilor District on swimming water contamination tests

C. By Third Councilor District on health careers

7. Report on Washington Trip

Doctors Drew, James, and Kief, and Mr. Maroney reported on contacts made with representatives in Washington during the U. S. Chamber of Commerce meeting and all felt the trip was worth while and should be continued annually. Doctor Kief proposed that the official Society delegation be augmented in the future by representatives of the Professional Association for Civic Education.

8. Special Report of the Secretary

In behalf of the Commission on Medical Care Plans, Mr. Crownhart reported on developments arising within the Seventh Congressional District relating to the possibilities of experimental programs with federal subsidy for payment of uninsured medical bills. He discussed some proposals under consideration, but indicated that the Commission had not yet arrived at definitive recommendations to report to the Council and House of Delegates.

As a related item of information, Doctor Hilliard was asked to report from his knowledge of a federal medical care plan for the "inner core" of Milwaukee. He urged that the Society find a way to participate in such planning so that the government is not planning "for" the people, but "with" those involved.

Chairman Fox suggested that the Council discuss such matters in depth at the earliest opportunity.

9. Recommendations of Committee on Grievances

A. Committee Name

The House of Delegates had suggested that this standing committee consider a name change. It did so and reported a preference to retain its present designation.

On motion of Doctors Egan–Sisk, carried, the Council accepted the recommendation.

B. Professional Courtesy

On motion of Doctor McRoberts, seconded and carried, the Council accepted the recommendation that a recent statement of the AMA's Judicial Council on professional courtesy be published for information of Society members.

10. Report of AMA Delegation

Doctor Bernhart, reporting for the delegation, asked councilors and officers to contact any personal acquaintances in the AMA House of Delegates in support of Doctor Simenstad's reelection to the board of trustees.

He also submitted a resolution intended to implement by AMA action the report of the secretary to the House of Delegates in 1967 on the privileges, responsibilities, and limitations of allied health professionals and paramedical personnel.

On motion of Doctors Ludwig–Hollenbeck, carried, the resolution was approved and forwarded to the House of Delegates.

11. Recommendation of Commission on Health Information

One of the assignments of this commission is to "study, make recommendations and implement approved activities to improve the distribution of medical service to the public." Concerned with physician shortages and distribution in Wisconsin, and recognizing that other committees are also interested in the subject, the Commission recommended that the Society call an action conference in the fall with representatives of the two medical schools, the medical licensing board, the Governor's Task Force on Medical Education, colleges and universities, the Legislature, and others with a direct concern in the supply and distribution of physicians for Wisconsin. It was estimated the cost of such a conference would approximate $1,500.

On motion of Doctors Sullivan–Chojnacki, carried, the recommendation was approved by the Council.

12. Recommendation of Division on Nervous and Mental Diseases

This division recommended that the Council establish a study of contractual relationships to review the responsibility and ethics of physicians, particularly psychiatrists, having agreements with industry, universities, or any educational facility, to care for the health of students or workers. In discussion, the Council felt that any existing problem must be largely a matter of communications.

On motion of Doctors McRoberts–Van Hecke, carried, the recommendation was tabled.

13. Tests for Intoxication

Legal counsel presented suggested guidelines for physicians administering tests for intoxication at the request of a law enforcement officer.

Doctors Houghton–Sisk moved that the guidelines be accepted and reported to the House of Delegates. An amendment by Doctors Egan–Schulz that action be postponed lost and the original motion carried.

14. Medicine and Religion

John O. Simenstad, M.D., Osceola, submitted a report on an AMA regional conference on medicine and religion which he attended as the Society's representative. He recommended that the Council proceed with appointment of a committee, suggesting five members representing various faiths and geographic areas, and indicated that staff assistance to augment that available from the AMA would be required, in addition to financial support of a program for medicine and religion.

On motion of Doctors Van Hecke–Ludwig, carried, the report was received with the stipulation that the matter come back to the Council with a fiscal note.

15. Report of Committee on Economic Medicine

Doctor Schulz reported matters reviewed by this committee Sunday morning, including status reports on existing insurance programs for Society members provided by the insurance consultants; enrollment in the annuity programs of Bankers Life and Prudential; and a proposal for professional and personal liability coverage under study. The committee has named Doctor Carey as vice-chairman.

On motion of Doctors Chojnacki–Houghton, carried, the report was accepted.

Doctor Sullivan requested that the matter of insurance for families of physicians be referred to this committee. (A resolution that WPS group coverage be made available to widows and dependent children of physicians was approved by the House in May 1968.)

16. Report of Executive Committee

A. Salaries of Principal Executives

In considering future policy on publication of salaries of the secretary and associate secretaries, the Executive Committee recommended that the House of Delegates be provided with combined executive salaries and percentage allocations to the Society and to WPS; total legal services to the Society and allocation to revenue-producing divisions; similar allocations in reference to consulting services of accountants, actuary, and investment counsel, with an annotation that details of each and every position can be had by any physician member of the Society from the Finance Committee of the Council.

On motion of Doctors Kief–Ludwig, carried, this recommendation was approved.

B. Commission on Safe Transportation

On motion of Doctors Kief–Hollenbeck, carried, the Council approved the following statement of organization:

PURPOSE

The Commission on Safe Transportation is created as a Council Commission to deal with the medical aspects of safe transportation and to make recommendations to the Council on this subject matter.

The scope of the Commission's activities includes not only the medical aspects of safe transportation on the highways of Wisconsin, but by direction of the House of Delegates, also includes safety upon inland waters.

In addition, the Commission is empowered to meet with representatives of the various agencies of state government concerned with setting standards and implementing laws and regulations and to give such agencies counsel and advice on the medical aspects of safe transportation.

MEMBERSHIP

The initial membership shall consist of members of the former Division on Safe Transportation. Terms will be for three years except that initial terms shall be established by lot for periods of one, two and three years so that approximately one-third expire annually. New appointments to the Commission shall be by the Chairman of the Council. The Chairman of the Commission shall be designated annually by the Chairman of the Council from one of the nine members of the Commission.

PROJECTS

The Commission may make project studies deemed necessary on medical aspects of safe transportation, including but not limited to alcohol and drugs; emergency care; licensing standards; school bus safety; motorcycle safety and water safety. Recommendations from such studies shall in no way bind the Council or any other commission, committee or division of the State Medical Society without the approval of the Commission and the Council.

C. Commission on Wisconsin's Health and Natural Resources

On motion of Doctors Kief–Egan, carried, the Council approved its organization as follows:

(1) Name: Commission on Wisconsin's Health and Natural Resources
(2) Appointment of the membership by the Chairman of the Council
(3) Initial appointments of nine physicians be for one, two and three years, and thereafter for three-year terms.
(4) The new group to define the scope of its activities, correlating them with those of similar bodies in the AMA and in other state societies, if the latter have them.
(5) Fiscal notes be expressly included in recommendations of the new commission.

D. Physician Immunity

In reference to action noted earlier on guidelines for physicians administering tests for intoxication at the request of a law enforcement officer, the Executive Committee also recommended that the Council go on record supporting the introduction of legislation which would grant immunity to a physician in such situation.

On motion of Doctors Kief–Ludwig, carried, the recommendation was approved.

E. Other Actions Reported

On motion of Doctors Van Hecke–Huth, carried, the Council approved additional actions reported by the Executive Committee:

(1) Reinstitution in the JOURNAL of a section similar to the Forum of several years ago for last-minute insertion of current information on medical economic matters.
(2) Retention of present bylaw provision on the scientific fellow classification with interpretation that it is intended for nonmedical individuals engaged in teaching one of the basic sciences as defined by Wisconsin statute.
(3) Acceptance in behalf of the Council and the Commission on Medical Care Plans of the invitation from the Michigan Medical Society to meet with its counterparts at Mackinac Island in July.

17. Report of Ad Hoc Committee on the Medical Practice Act

Mr. Maroney reported that this committee has met at least six times in review of present provisions on the licensing of physicians and in exploration of the status of paramedical personnel and methods of increasing their numbers.

On motion of Doctors Nordby–Ludwig, carried, the report was accepted.

18. Request of Wisconsin Health Council

On motion of Doctors Chojnacki–Houghton, carried, the Council approved the request that Society membership records be made available for direct mail solicitations to membership in the Wisconsin Health Council and for contributions to support its health careers program.

19. Report by Woman's Auxiliary

The Council received a written report on Auxiliary activities, and heard remarks by its President, Mrs. Britton, and President-elect, Mrs. Sargent, who asked for assistance of councilors in organizing auxiliaries in those counties where they do not exist.

20. Report on PACE

Gunnar Gundersen, M.D., and Mr. Paul Weise reported for information on educational activities of the Professional Association for Civic Education.

21. Nontherapeutic Sterilization

On motion of Doctors Ludwig–Schulz, carried, the Council received and forwarded to the House of Delegates a status report on the Society's request through the State Board of Medical Examiners for an updated opinion of the attorney general on nontherapeutic sterilization, together with a proposed resolution.

22. Memorials

Chairman Fox asked all present to rise in silent tribute to the memory of Doctors John Houghton and Milton Davis.

He then announced that he had requested his district to elect another representative to the Council, and expressed his thanks for the privilege of service for a number of years.

23. Adjournment—5:30 p.m.

Respectfully submitted,
C. H. CROWNHART
Secretary

Approved:
JAMES C. FOX, M.D.
Chairman
(Subject to formal approval by the Council.)

MINUTES OF COUNCIL MEETING

MILWAUKEE, MAY 15, 1968

1. Call to Order and Roll Call

The meeting was called to order by Vice-chairman Nordby at 10:35 a.m. on Wednesday, May 15, 1968, at the Sheraton–Schroeder Hotel, Milwaukee.

Present: Doctors Bayley, Schulz, Nordby, Stoops, Huth, McRoberts, Sisk, Dettmann, Rohde, Boren, Ludwig, Manz, Grand, Egan, Sullivan, Van Hecke, Chojnacki, Hollenbeck, Wright, Drew, Kief, Behnke; James, Nereim, Callan; Bernhart, Galasinski, Picard, and Fox.

Staff, consultants and guests: Messrs. Crownhart, Thayer, Koenig, Brower, Maroney, Johnson, Gill, White, Murphy; Mrs. Anderson and Miss Pyre; Jack Brown and Leon Swatzell, AMA field representative; Dr. Newton DuPuy, President, Illinois State Medical Society; Mr. James Waggener, Executive Secretary, Indiana State Medical Association.

2. Election of Officers

By separate motion duly made, seconded and carried, the following were unanimously elected:

A. Chairman of the Council: E. J. Nordby, M.D., Madison

B. Vice-chairman: J. M. Sullivan, M.D., Milwaukee

C. Treasurer of the Society: F. L. Weston, M.D., Madison

D. Assistant Treasurers:
   H. Kent Tenney, M.D., Madison
   N. A. Hill, M.D., Madison
   J. T. Sprague, M.D., Madison
   R. A. Sievert, M.D., Madison

E. Medical Editor, WISCONSIN MEDICAL JOURNAL (two year term): V. S. Falk, Jr., M.D., Edgerton

F. Editorial Director: D. N. Goldstein, M.D., Kenosha

3. Commendations

Chairman Nordby entertained motions commending Doctor Fox for his many years of service to the Society and to the Council, and Past President Drew in particular for the past three years since he became President-elect, passed by acclamation.

4. Oath of Office

Doctor Nordby administered the oath of office to E. P. Rohde, M.D., as seventh district councilor, and to R. E. Callan, M.D., president-elect.

5. Organization of the State Medical Society

A. Doctor Nordby referred to provisions in the constitution and bylaws relating to the duties of councilors as trustees. He also asked that any member having items they would like included on the agenda submit them with appropriate supporting information for advance distribution and consideration before a Council meeting.

B. Mr. Crownhart presented slides with commentary on the organization of the Society, its divisions, and affiliated organizations.

6. Announcements

Councilors were reminded of the date of June 30 for the reception for President James, and the Council meeting at Mackinac Island, July 18–20.

7. Adjournment—11:30 a.m.

Respectfully submitted,
C. H. CROWNHART,
Secretary

Approved:
E. J. NORDBY, M.D.
Chairman
(Subject to formal approval of the Council.)

BOOKLET: LEGAL ASPECTS OF PHS MEDICAL CARE

A self-instruction publication titled, "Legal Aspects of PHS Medical Care—A Programmed Instruction Course," was announced May 20 by the Health Services and Mental Health Administration of Public Health Service. It is a companion piece for use with a reference booklet by the same title.

The material is intended to show legal obligations and barriers that PHS physicians and other medical-health personnel face when they treat patients in facilities of the Public Health Service. However, non-Governmental medical people meet many of the same problems in the private practice of medicine. The two manuals should prove helpful to physicians generally, administrators of all medical facilities, nurses, other providers of medical care, and students of public health.

Both publications are on sale from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. The programmed instruction manual (PHS Publication No. 1468-A) is 55 cents. The related reference booklet (PHS Publication No. 1468) is 50 cents. Single free copies are available from Public Inquiries Branch, U. S. Public Health Service, Washington, D. C. 20201.

* * *

NURSING MANAGEMENT OF THE PATIENT WITH CANCER—A recently released American Cancer Society film for registered nurses, licensed practical nurses, student nurses, medical students and nursing home staffs. The film presents comprehensive nursing procedures for patients who have had a laryngectomy, colostomy, tracheotomy and cystectomy. Running time: 29 minutes; call your local ACS to make screening arrangements.

WISCONSIN MEDICAL JOURNAL
VOL. 67, NO. 7 JULY 1968

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Regional Medical Program: Where Is It Going? A Report on Plans and Progress in Wisconsin

Wisconsin Regional Medical Program is two years old this month. What are its goals? Who is involved? What has it done? Where is it going?

To find the answers the Green Sheet Editor attended the first annual meeting of WRMP in Madison on June 29. It was a gathering of about 50 men and women from across the state who serve on the advisory board and special committees of this burgeoning agency.

WRMP was designed, to use its own words, to "speed the findings of science to serve patients . . . a region-wide attack on cancer, heart disease, stroke and related illnesses . . . with primary reliance on cooperative arrangements using local initiative, local resources."

What are the answers?

One: WRMP is making progress. Compared with other states Wisconsin's RMP may even be out in front, if not with quantity, perhaps with quality.

Two: "Progress" is the term attached by most of the WRMP planners to the fact that a host of medical and health care situations—some of them "problems"—are being identified and analyzed for possible solution.

Three: No one is quite sure where to go or what to do next, in specific terms.

Four: Those participating in WRMP seem dedicated to the proposition that Regional Medical in Wisconsin shall be a boon not a boondoggle in health care.

WRMP is operational in Wisconsin. It was the fifth program in the nation to get out of planning into the "do" stage. There are five operational projects to prove it—one dealing with pulmonary thromboembolism, one with uterine cancer, and three in postgraduate education.

Nationally, there are 54 medical regions. Fifty-three of these have set up programs and each has received a planning grant of federal funds. To date, only 13 regions have received "operational grants." One of these is Wisconsin.

HIRSCHBOECK

WRMP has inventoried nearly 30 projects in application form. So far only five have been approved and funded, but one other is near the "go" stage, and five more have been ok'd by WRMP and are waiting Washington's signal.

There are many meetings and lots of talk by the WRMP's eight major committees and several subcommittees made up of more than 150 physicians, nurses, planning engineers, professional health personnel and interested citizens plus support from 33 "collaborating organizations." In addition, WRMP has a full-time staff of 12 plus several part-timers.

Federal funds have come into WRMP at an increasing rate . . . $320,000 for the first year (planning) and about $530,000 for its first operational year (since Sept. 1, 1967). There is expectation of a budget in the neighborhood of $1,800,000 for 1968–69, if all recommended projects are funded.

And there's concern about what problems to tackle first, how to prod without dictating, how to keep the program within bounds, when to terminate pilot projects, and how to put

(Continued on page 355)

SMS Had Role in Start of WRMP in Wisconsin—Here's the Story

Regional Medical Programs began when Congress passed Public Law 89–239 in October 1965. The purpose of the law was to help make the best in modern medical science readily available to all people who suffer from heart disease, cancer and stroke and related diseases, or are threatened by them.

To accomplish this, PL 89–239 seeks to "establish direct linkage between the patient, his physician, his community hospital, and the nation's centers of scientific medicine. The principal purpose is to speed the transmission of scientific knowledge and methods to the people whose lives depend on them."

WRMP Policy on Cooperative Arrangements

Reprinted below are the most pertinent parts of a policy statement developed and approved by the Regional Advisory Committee of WRMP dealing with cooperative arrangements within the Wisconsin region.

. . . We believe that the principal role of the Wisconsin Regional Medical Program is that of a catalyst to bring about development of programs through local initiative. If programs are to be region-wide in content and quality, local effort should be channeled not only into area-wide but also into region-wide planning.

We recognize that resources, particularly in health manpower, are frequently inadequate to meet existing programs. Therefore, every effort should be made to avoid unnecessary duplications of resources, improve the effectiveness of existing resources, and avoid establishing programs which will deplete one program to augment another.

We favor arranging for continuing data collection and evaluation of such data to assure the most efficient use of the available resources and optimum distribution of the various health services in the region, particularly those for heart disease, cancer, stroke and related diseases.

We favor proposals which will complement and supplement existing resources and programs on establishing new agencies and new resources.

We favor the carrying out of operational programs through contracts or agreements with other agencies rather than the Wisconsin Regional Medical Program conducting operational programs itself.

We will encourage, whenever possible, the development of collaborative programs between the university medical centers and medical centers in the region capable of conducting programs which meet medical school standards.

We urge those who plan regional medical programs to obtain the cooperation and, if necessary, the approval of the various health professional societies during the planning process so that proposals which are to be presented to WRMP are acceptable to the various professions and deemed feasible by these groups.

We urge the medical staff, administrators, and trustees of hospitals to share, whenever possible, the responsibility for developing and operating regional medical programs.

We favor a continuing program of public information to acquaint the public, and especially health organizations, with the work of the Wisconsin Regional Medical Program in order to foster awareness of and interest in the activities of WRMP and to promote the growth of cooperative arrangements.

Even prior to enactment of the law, the State Medical Society played a part in laying the groundwork for the development of Regional Medical Planning in Wisconsin.

The WRMP annual report states that a "conference with the Executive Council of the SMS and the deans of the two medical schools resulted in an agreement that initiative for any Wisconsin RMP would be taken by the medical schools rather than some other agency. It was also agreed that the State Medical Society should have a key role in RMP."

WRMP was incorporated in July 1966 by three men: Edmund Fitzgerald, retired president of Northwestern Mutual Life Insurance Co.; Fred Harvey Harrington, president of the University of Wisconsin, and the Rev. John P. Raynor, S.J., president of Marquette University.

A federal grant of nearly $320,000 was obtained to enable planning, a board of directors was appointed with Mr. Fitzgerald as president, and Dr. John S. Hirschboeck, former dean of Marquette School of Medicine, was appointed Program Coordinator and head of program staff.

One of the first acts of the Board of Directors was to appoint a Regional Advisory Committee as required by law. This group, broadly representative of the public in Wisconsin, must give approval to all major policies and operational projects. See page 356.

Then a Planning Committee was named. It consists of three technical committees and prepares policy and projects for presentation to the Advisory Committee.

There are a number of special committees and task forces to assist in planning and evaluation of projects dealing with the various diseases of concern under the law. See page 356. Most importantly, the Regional Advisory Committee to WRMP has laid down a set of guidelines for the way in which the program is to work in Wisconsin. Pertinent excerpts are reprinted in neighboring columns.

Thus, while most of the RMP's in the country are still in the formative stages, the Wisconsin Regional Medical Program is well into operation.

5 Projects Okayed: Show Direction of WRMP

UTERINE CANCER STUDY IS FIRST PROJECT OK'D

A study program for uterine cancer therapy and evaluation is a WRMP project under the direction of Dr. Ben M. Peckham, Madison, of the University of Wisconsin Medical School.

The purpose is to develop a readily available dosimetry service for radiation therapy of uterine cancer.

It is hoped that it will ultimately permit the establishment of local centers from which new techniques in the management of uterine cancer can be disseminated on call, possibly by computer hook-up, to physicians and hospitals throughout the state.

The study began as a cooperative arrangement between the departments of gynecology and radiation therapy at University Hospitals in Madison and Milwaukee County Hospital.

It is now expanded to other institutions through computer and teletype arrangements, thus providing a detailed picture of radiation dosage for every patient treated in these centers.

Also involved is a small computer, the LINC, which is used in questioning patients and their physicians, thus assuring the gathering of data within the same relative terminology.

This pooling of information will make possible far more adequate evaluation of the methods of treatment as related to the results (cure).

THROMBOEMBOLIC DISEASE IS LATEST WRMP PROJECT

A demonstration program for pulmonary thromboembolism was authorized by WRMP under direction of Dr. Richard D. Sautter, Marshfield.

Pulmonary thromboembolism is a common disease present in 64% of autopsied deaths. Deaths in Wisconsin from this cause exceed national rates.

The project involves cooperative arrangements between the Marshfield Clinic, several hospitals in the central Wisconsin area, and the two medical schools.

The goals of the project are to devise means for more rapid diagnosis and treatment of patients with thromboembolic disease, develop centers for management of patients in acute danger of primary or recurring thromboembolism, and acquire more facts on the extent to which this disease is a factor in morbidity and mortality in Wisconsin.

Thus far, the team of investigators has developed a protocol on diagnosis and treatment which is available to physicians.

In addition, a 24-hour telephone consultation service has been initiated for physicians confronted with problems by their own patients.

POSTGRADUATE EDUCATION PROJECTS UNDER WAY USING NEW TECHNIQUES

Three separate but inter-related WRMP projects in the field of postgraduate education are under the direction of Dr. Thomas C. Meyer, assistant dean at the University of Wisconsin Medical School, with the aid of Roy T. Ragatz, Madison, WRMP Postgraduate Education Coordinator, and Mrs. Signe S. Cooper, R.N., of the University Extension department of nursing.

The Dial Access Medical Library for Physicians is the first of these projects. Through it, more than 250 informational tapes on topics in heart disease, cancer, stroke and related diseases are made available to all physicians on a 24-hour basis. A toll-free telephone call brings the physician a 5–6 minute lecture from authorities in many fields.

Mr. Ragatz reports that from January to May, 1968, 3,579 Dial Access calls were made. Of these 1,343 were from general practitioners, 1,068 from specialists, 915 from residents-interns-medical students, 31 from osteopaths, and 222 from nurses and others.

Most of the calls came between 6 p.m. and midnight.

A second project of postgraduate education involves Dial Access Information for Nurses.

This is a take-off on the medical project, with about 50 tapes beamed to the nurse audience.

Mrs. Cooper indicates Dial Access for Nurses will get under way about September although some testing is being done now.

The third project deals with "Single Concept Films" for physicians. Films with automatic projectors are now being tested in the physicians' rooms of 40 hospitals throughout the state.

By November, WRMP plans to offer every hospital medical staff a postgraduate educational package of projector and one-film-a-week for six weeks.

REGIONAL MEDICAL PROGRAM

(Continued from page 353)

good projects on a permanent basis after federal funds stop.

Through all the discussions, it is encouraging to hear RMP members remind each other to "stick to the goal": to serve as a catalyst helping to assure every citizen that his doctor has the know-how to provide the best possible medical care.

Where is WRMP going in the years ahead?

Postgraduate educational activities are high on the list for some time to come. Specific disease projects, visiting professorships to hospital medical staffs, and continuation centers for MDs scattered through the state (starting in northern Wisconsin) are already on the boards.

Next in priority seems to be more efficient use of MD manpower and efforts to induce greater use of nurses and other types of personnel for tasks now principally performed by physicians.

The latter area is one in which Comprehensive Health Planning is also proposing action. Dr. Hirschboeck foresees the need for WRMP and WCHP to merge their interests and programs on some items as time goes on.

These People Direct Wisconsin Regional Medical

BOARD OF DIRECTORS

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Rodney Lee Young, Ladysmith, Attorney

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Roy T. Ragatz, Madison, Postgraduate Education Coordinator
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Sister M. Thomas, O.S.F., Milwaukee, Dean, Marquette University College of Nursing
Martha R. Jenny, R.N., Madison, Wisconsin Nurses Association
Agnes A. Shoemaker, R.N., Milwaukee, Marquette University College of Nursing

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NORMAN O. BECKER, M.D., Fond du Lac
Roswell K. Boutwell, Ph.D., Madison
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JAMES R. HOON, M.D., Shehoygan
JOHN D. HURLEY, M.D., Milwaukee
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HEART STUDY GROUP

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DERWARD LEPLEY, JR., M.D., Milwaukee

(Continued on page 357)

WHAT HAPPENS WHEN WRMP MONEY STOPS?

When do "pilot projects" end in WRMP? If WRMP money stops, what happens to the project?

In other words, who blows the whistle, and when, on WRMP funded projects?

Participants at the WRMP Annual Meeting in Madison June 29 kept raising the questions, but only vague answers were available.

Program Coordinator John S. Hirschboeck says it's because "we don't really have all the answers. We will no doubt expect advice from our medical study groups as they evaluate each project, and our Regional Advisory Committee will have a lot to say about this."

Dr. Ben Peckham, Madison, chairman of the uterine cancer study project said he hoped that, if it proves successful, the project might become a part of the continuing program of one or both of the two medical schools.

Roy Ragatz, speaking for the Dial Access Medical Library and Single Concept Film projects, thought they might continue within the tax-funded postgraduate education programs of the university or possibly stay alive through the support of some yet undiscovered "angel."

As for when or if the projects will be "cut off" from WRMP funds . . . no one knows right now.

DIRECT REGIONAL MEDICAL

(Continued from page 356)

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Rules for WRMP Project Funding

Strict limitations are currently in effect on the types of projects which might win approval for funding in WRMP.

At the same time there is flexibility to meet unusual situations, according to WRMP administrators.

For example, WRMP won't OK a project to equip an intensive care unit. It will support a project to train personnel for intensive care units.

WRMP does not contemplate general support for facilities or equipment, yet it has aided pilot projects with money for equipment, including a favorable recommendation to provide up to $90,000 for coronary angiography equipment in one pilot study.

In the gross sense, a proposal must relate directly to one of the four specific disease entities covered by the law. It must relate to the health of all the people in the region. It must make a significant contribution to prevention, diagnosis, treatment or post treatment health care.

Then it runs the gamut of analysis by a medical study committee whose individual interests and experience relate to the field being proposed.

WHO TO CONTACT ON IDEAS OR QUESTIONS

John S. Hirschboeck, M.D., Program Coordinator, Wisconsin Regional Medical Program, Inc., 110 E. Wisconsin Ave., Milwaukee, Wis. 53202, or tele. Area 414–272–3636.

State Medical Society of Wis., Box 1109, Madison, Wis. 53701 or tele. Area 608–257–6781.

Outlines Route for WRMP Proposal

WRMP operates by encouraging others to find new, better and more efficient ways to diagnose, treat, or rehabilitate those afflicted with heart disease, stroke, cancer, emphysema and related conditions.

It does this through projects of education, research, service and communications.

A common question is: "I'm a physician with an idea; will WRMP help me try it out?"

Program Coordinator Dr. John S. Hirschboeck says "we are willing to listen and explore every idea that might possibly serve the goals of this program."

WRMP would like anyone with proposals related to the four diseases to submit a summary of the idea. It would be assigned to a medical study group which would contact the originator, usually with a view to personal discussion of the idea.

If the proposal seemed to offer possibilities within the intent of the law, the WRMP staff and study groups would assist the originator in developing the idea fully for approval by the WRMP Planning Committee, then the Regional Advisory Committee, and finally the Board of Directors.

It is then forwarded to Washington, D.C., to obtain approval for funding through the National Institutes of Health.

WRMP Seeks Ties With Medical Societies

County medical societies are invited to cooperate closely with WRMP.

Program Coordinator Dr. John S. Hirschboeck reports that WRMP committees frequently call upon county societies to provide advice about facilities, services and availability of manpower.

"We welcome the direct interest of the medical society," he said. "We are especially pleased with the example provided by one county society which has set up an active committee to monitor WRMP projects in its area."

Membership Urged to Use Services of SMS Regional Representatives

With the recent assignment of a fourth representative, the Regional Services Division of the State Medical Society is now prepared to provide "full-strength" services to county societies and individual physicians throughout the state.

Under the direction of John C. LaBissoniere, Madison, at the Society headquarters, Regional Representatives serve as "two-way-street" liaison between the membership and headquarters. These men and their territories are:

Western—Elmer B. Sandeen
Central—Glenn W. Waldschmidt
Eastern—Eric P. Jacobson

LaBissoniere also services the Southern Wisconsin territory.

County medical societies and physicians throughout the state are urged to utilize their services and assistance at any time.

The Regional Representative is expected to periodically call on each physician and attend county society meetings with regularity.

He is to provide information to members concerning Society affairs, assist members as requested within his capabilities, aid physicians and their personnel with Medicare and Medicaid problems, serve physicians in their relationships with WPS–Blue Shield programs, especially in the application of the "usual, customary and reasonable" philosophy, assist in grievance matters, and similar affairs of the Society.

At the same time the Regional Representatives assist members and county societies with public relations programs, relationships with hospitals and other health agencies, and channel reports of public opinion on health matters to the attention of the Society.

Every member is urged to welcome the Regional Representatives and to utilize their services as needed.

WALDSCHMIDT

LaBISSONIERE

John C. LaBissoniere is SMS Director of Regional Services and at the same time services the Southern Wisconsin territory. Formerly in pharmaceutical sales with Ayerst Laboratories, John was employed by SMS in 1954, first as a district sales coordinator for WPS and later as statewide coordinator. He and his wife Mary Lou and four children live in Madison, and he offices at the Society headquarters. Tel.: (608) 257–6781.

Glenn C. Waldschmidt is the Regional Representative serving the Central Wisconsin area. A former life insurance salesman and Eau Claire District Manager for WPS, Glenn has been an SMS Regional Representative for almost 8 years. He and his wife Beverly and three children live in Rothschild. He can be reached at (715) 359–4112.

SANDEEN

JACOBSON

Eric P. Jacobson services the Eastern Wisconsin territory as Regional Representative of SMS. Prior to this assignment he was with the WPS division in sales, underwriting and Medicaid claims. He and his wife Jacqualine live in Appleton. His telephone is (414) 739–4060.

Elmer B. Sandeen is Regional Representative in the Western Wisconsin territory. Formerly office manager for the Geo. Walter Brewing Co., Eau Claire, and an agent for Massachusetts Mutual Life Insurance Co., Sandeen came to the WPS sales division in 1962. He transferred to Regional Services in July 1968. He and his wife Myrtle now live in Rothschild, but he will soon headquarter in Eau Claire. He can be reached at (715) 835–6167.

SWATZELL

RUECKERT

NEW AMA FIELD REP

The American Medical Association Field Representative serving Wisconsin is Leon J. Swatzell. After six years with the National Steel Corporation, Leon joined the AMA field staff and will work with the Michigan, Wisconsin and Minnesota societies. He will be in frequent contact with the state and county society officers.

RUECKERT NAMED TO HEALTH COUNCIL

Dr. Ray R. Rueckert, Portage, has been appointed to the Council on Health (formerly State Board of Health) by Governor Warren P. Knowles.

He succeeds the late Dr. John H. Houghton, Wisconsin Dells, for the remainder of an unexpired term ending in 1973.

Dr. Rueckert is a U.W. medical school graduate practicing internal medicine. He is a member of the Society's Commission on Medical Care Plans, Division on Handicapped Children and Public Policy Committee.

Two Tattoos Are Two Too Many!

Most people who have been tattooed (marked) sooner or later come to think they were tattooed (slang)!

This is the conclusion of the Division of Maternal and Child Welfare of the State Medical Society which reports too many adolescents complaining they are too tattooed.

Apparently many young people think the tattoo is "in," but upon maturity wish it were "off."

Taking off a tattoo is quite a problem, if not almost impossible, according to plastic surgeons who get most of the requests.

Right now, no one seems to know what to do about it, but the Society's division is sounding a tattoo (call) for some way to tattoo (drum) the tattooers out of business.

Small Plants Get Health Service Help

Occupational health programs for small plants and industry without full-time health personnel are being planned by the Committee on Occupational Health of the State Medical Society.

At a meeting in Madison June 20, the committee under the chairmanship of Dr. J. M. Wilkie, Madison, proposed development of a guide of recommended standards for such small-plant health services.

A conference on pesticides and insecticides is in the planning stages, and may be combined with a program of farm safety and accident prevention.

The committee reports that it has distributed 1,376 copies of its recently revised Occupational Health Guide.

MEDICAL ASSISTANTS CHOOSE NEW PRESIDENT

Self-help educational programs will continue to be the major effort of the Wisconsin State Medical Assistants Society in 1968–69 under the leadership of President Mrs. Jane Staszewski, Big Bend, Wis., an employe of Dr. J. L. Rashbacher.

At the 13th Annual Meeting of the group in June, Mrs. Staszewski announced plans for a leadership training seminar in Wausau on Sept. 14 and other educational meetings later.

All members of the Society are invited to the programs.

Also announced were representatives to the Wisconsin Health Council, Wisconsin Council of Safety, and the Advisory Board to the State Department of Vocational and Adult Education.

OB COURSE FOR NURSES TO BE EVALUATED

A study of postgraduate programs for nurses is to be undertaken by a special committee of the State Medical Society's Division on Maternal and Child Welfare.

The study will evaluate a recently conducted two-week workshop in obstetrical nursing at Marquette School of Nursing and St. Joseph's Hospital in Milwaukee. The course was attended by 140 nurses from 65 hospitals.

SIMENSTAD REELECTED TO AMA TRUSTEES

Dr. L. O. Simenstad, Osceola, was reelected to a second three-year term as a member of the Board of Trustees of the AMA at the recent convention in San Francisco.

Immediately thereafter he was named to the Executive Committee of the Board.

Doctor Simenstad has served in the AMA House of Delegates since 1954. During that time he was active in many committees involving military medicine, national security, legislation, and world medical affairs.

Since winning election to the Trustees in 1963 he served as chairman of the AMA's delegation to the Joint Commission on Accreditation of Hospitals, a member of the AMA Committee on the Costs of Medical Care, and recently as vice-chairman of the Board.

SIMENSTAD

HILDEBRAND

HILDEBRAND ELECTED TO AMA COUNCIL

Wisconsin was honored at the recent San Francisco meeting of the AMA by the election of Dr. William B. Hildebrand to membership on the AMA Council on Medical Service.

Since he fills an unexpired term of another physician, Dr. Hildebrand will hold office until 1970.

The Council on Medical Service functions in the area of planning for medical care, distribution of health services, and health insurance.

Dr. Hildebrand is a past president of the Wisconsin State Medical Society of Wisconsin and the American Academy of General Practice. He is a member of the Joint Commission on Accreditation of Hospitals, the Advisory Board of the Sears–Roebuck Foundation, and a number of other civic and medical activities on the state and national level.

SMS Hot Line

SURVEYS A-GO-GO—The Wisconsin summer is "swinging" with health surveys: Congressman Laird has announced a $158,913 Office of Economic Opportunity grant to Wisconsin State University-Stevens Point Foundation to survey "marginal farmers, retirees, unemployed, and underemployed persons" to determine "how much health service is required and how much is being received." The survey area is reported to be Marathon, Wood, Portage, Clark, and Taylor counties. A $29,700 comprehensive planning survey is being urged for "Madison and area medical needs" to study financing of patient care services, modifications in diagnostic and therapeutic procedures, and trends in the organization of medical care services. A similar study also is under consideration for central Wisconsin.

LAYING ON THE HANDS—The Wisconsin Public Welfare Association meeting in Eagle River in mid-June held a show-of-hands vote which ended with a 101 to 69 count in favor of including chiropractic services under Title XIX, Medicaid.

NEW PHARMACY DEAN AT U.W.—Ph.D. David S. Perlman has taken over as dean of the University of Wisconsin School of Pharmacy with visions of the day when pharmacy graduates will "take a leading role in the medical team, participating in the making of policy as well as carrying it out." A 20-year researcher with Merck and Squibb he is excited about prospects of increasing cooperation between the medical and pharmacy schools.

OPEN HOUSE—The Museum of Medical Progress and Stovall Hall of Health will hold Open House on Friday July 26 at Prairie du Chien. Physicians and their families are cordially invited . . . a day to remember.

SOMETHING TO THINK ABOUT—Just suppose your hospital has an Intensive Coronary Care Unit. Suppose not every member of the medical staff knows how to use, or doesn't care to use, the unit's specialized equipment. And suppose one of those physicians is the only M.D. in the hospital when there is a coronary emergency. What is his legal obligation? Probably only that expected without such equipment, except to promptly call for qualified assistance. Hospital boards of trustees and medical staffs would do well to anticipate such problems when they consider installation of sophisticated treatment devices.

YOU BE THE JUDGE—Dr. John S. Hirschboeck, Program Coordinator for Wisconsin Regional Medical Programs, tells his colleagues: "Our goal is to become an effective means to assist physicians and hospitals in providing their patients with medical service of high quality, quickly, efficiently, and close to home. We will plan carefully, use pilot projects, and evaluate what we are doing. The measure of our success will ultimately be judged by the medical profession."

NEXT MONTH: Comprehensive Health Planning . . . where is it going?

the wisconsin medical journal

VOLUME 67/NUMBER 8 AUGUST 1968

Thymoma: Diagnostic and Therapeutic Aspects

By ROBERT B. SKOR, M.D., WALTER H. JAESCHKE, M.D. and HALVOR VERMUND, M.D., Ph.D., Madison, Wisconsin

■ THYMOMA, ALTHOUGH a rare tumor, has generated considerable interest for more than half a century. In 1900, Grandhomme[1] applied the term 'thymoma' to all malignant tumors of the thymus, regardless of their histologic structure. The extremely varied microscopic picture presented by these tumors has caused considerable difficulty for pathologists in determining their true nature. As a result numerous classifications have been established based on the presence and distribution of various cell types. One of the greatest problems has been in differentiating primary tumors of the thymus from metastases to this gland and from involvement of the thymus as part of generalized lymphomatous disease. Neither has there been agreement on the criteria establishing malignancy. Microscopically, this cannot be determined and it is often the surgeon's evaluation of capsular invasion which is necessary for malignancy to be diagnosed.

The clinical behavior of thymomas is also quite varied; some are slow growing, well encapsulated tumors which cause the patient no symptoms and are first detected on routine chest roentgenogram. Others are rapidly growing and invasive causing compression of the superior vena cava. At surgery they may be impossible to completely remove. There are, of course, all shades of behavior between these two extremes.

We have undertaken in this report a review of all cases of thymoma diagnosed and/or treated at the University of Wisconsin Hospitals since 1950. Our primary interest has been in determining the response of these tumors to various modes of therapy and especially the effect of radiation therapy. Being well aware of the difficulty in establishing a classification of thymic tumors, we have sought to divide them on the basis of what we believe to be the predominant cell type and to classify each as invasive or noninvasive. We hoped to find whether response to radiation therapy varied with predominant cell type.

Material

Hospital records between 1950 and 1966 revealed 29 cases in which the diagnosis of thymoma had been made. Evaluation of the individual case records and review of the microscopic sections of the tumors showed that only 22 of the tumors were actually thymomas. In two patients thoracotomy was never performed so there was no tissue diagnosis. Two patients had reticulum cell sarcoma involving the mediastinum and eventually other parts of the body. Two other cases demonstrated mediastinal lymphosarcoma which could not be established as arising in the thymus. One of these patients, a 7-year-old girl, died 13 months after diagnosis of leukemia. The other patient, a 30-year-old man, died six and a half months after diagnosis of widespread lymphosarcoma. A seventh case upon review was considered a Hurthle cell tumor of the thyroid. During this period there were two other patients with lesions of the thymus, one a

From the Sections of Radiation Therapy and Surgical Pathology of the University of Wisconsin Medical School.

Presented at the meeting of the Wisconsin Radiological Society, Oshkosh, Sept. 16, 1967.

Supported in part by National Institutes of Health Grant No. P02-CA 06295-06 RAD.

Doctor Skor was American Cancer Society Fellow in Radiology, July 1, 1966 to June 30, 1967.

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17-year-old man with a teratoma and the other a 48-year-old man with an epidermoid cyst.

Clinical Considerations

Sex and Age

Eleven patients were male and 11 female. The age distribution is presented in Table 1.

TABLE 1—*Age distribution*

	30–39	40–49	50–59	60–69	70–79	80–89
Male	1	3	2	2	2	1
Female	1	3	5	2	0	0

Average age with myasthenia gravis: 53.
Average age without myasthenia gravis: 53.

Symptomatology

The most frequent presenting symptoms are shown in Table 2.

TABLE 2—*Most frequent presenting symptoms*

	Malignant	Benign
Asymptomatic	3	1
Chest pain	4	3
Dyspnea	2	3
Cough	3	3
Superior vena cava syndrome	2	0
Myasthenia gravis	2	4

Patients with malignant and benign tumors presented with similar complaints of chest pain, cough, and dyspnea. The six with myasthenia gravis (MG) all presented with characteristic symptoms, four had benign tumors, and two had malignant tumors. In addition to weakness one patient with a benign tumor also had cough, dyspnea, and chest pain. One patient with MG and a malignant tumor had chest pain and cough.

Three of the four patients who were completely asymptomatic are alive and doing well at 50, 104, and 108 months after diagnosis. These three patients had malignant tumors which were seen on chest roentgenograms taken for other reasons. It appeared that patients with benign tumors presented as frequently with chest pain, cough, and dyspnea as those with malignant tumors. These symptoms were not a guide to prognosis. The two patients with superior vena cava (SVC) syndrome, however, had extensive tumor compressing the SVC and resection was not possible. This finding strongly suggests invasive tumor.

Radiographic Findings

Generally, the thymus is located retrosternally in the anterior mediastinum, but may lie anywhere in the anterior or middle mediastinum from the neck to the diaphragm. Its cephalocaudad position in these unusual cases is due to failure of the thymus to descend into the thorax or overdescent during the development phase. The thymus in the adult is rarely seen on roentgenograms unless involved by tumor.

All the patients in our series presented with anterior mediastinal tumor on chest x-ray film, except one 48-year-old woman who had a thymectomy for treatment of MG and a tumor was found.

It was not possible to review the x-ray films in each case but those available demonstrated tumors of various size lying in the anterior mediastinum. In posteroanterior (PA) projection they varied from rounded masses (Figs 1 and 2) extending to one or both sides of the mediastinum to flat lesions barely distinguishable from the heart and aorta. In several cases the masses were overlying the hilar area (Figs 1 and 3). In some cases oblique views were obtained and these best demonstrated the tumor (Fig 4). It has been suggested that if the tumor extends to both sides of the mediastinum it is malignant and if confined to one side it is benign.[2] From the films available in our cases we found that these criteria did not hold true. There were two good examples of malignant thymomas which presented extending to only one side of the mediastinum (Figs 1 and 3).

The tumor can usually be best seen in the lateral view and routine PA and lateral films are sufficient to diagnose most thymomas. Occasionally oblique views will demonstrate a tumor not seen on routine films and sometimes overpenetrated (Bucky) films are needed to outline the mass.

If the diagnosis of MG is available to the radiologist, PA, lateral, Bucky, and oblique views should be obtained to avoid missing a small tumor not seen on routine x-ray studies.

Differential diagnosis includes other tumors occurring in the anterior mediastinum. Thymomas are the most common tumors in this area with lymphomas second.[3] Teratomas, metastatic carcinoma, substernal thyroid, aortic aneurysm, enlarged pulmonary artery, and enlarged heart chambers can all be confused with a thymoma. Fluoroscopy

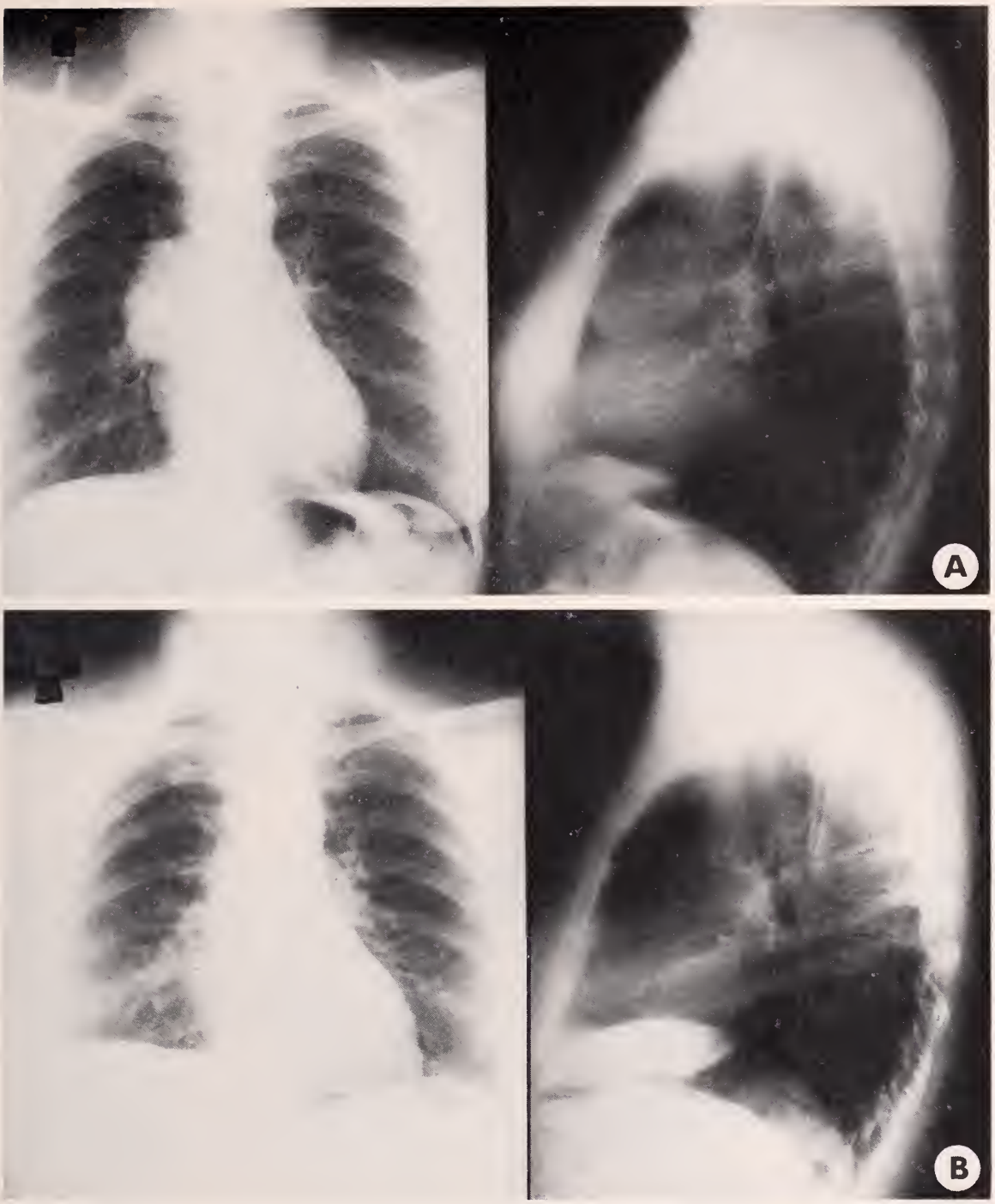

Fig. 1—(a) Typical appearance of a thymoma lying in the anterior mediastinum of an asymptomatic 38-year-old woman. It was found to be an invasive spindle cell tumor. (b) Same patient nine years after surgical removal and 2024 rads postoperatively to the mediastinum over 14 days. She is alive and well.

may demonstrate the nonpulsatile thymoma, separating it from an underlying vascular structure. But in some cases angiography may be necessary to eliminate an aneurysm. Substernal thyroid may be suggested if there is obvious extension into the neck with tracheal deviation. Also I-131 scan may define the mass as thyroid. Lymphoma, teratoma, and carcinoma metastatic to the anterior mediastinum may be impossible to differentiate on x-ray studies and thoracotomy will be necessary for tissue diagnosis.

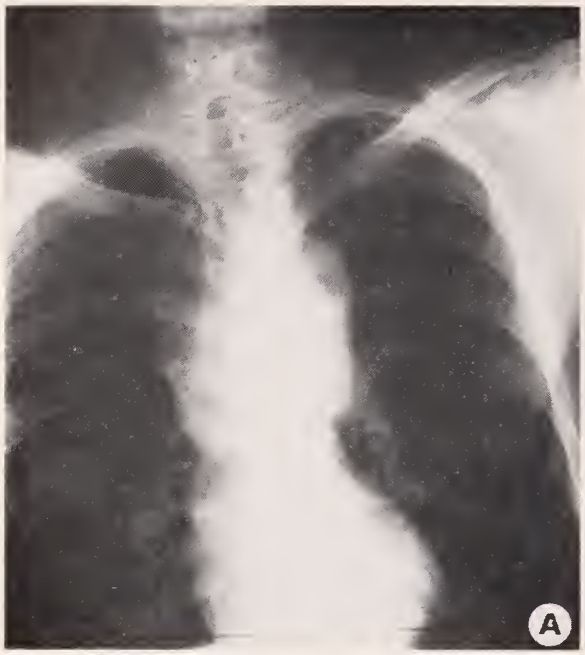

Fig. 2—(a) October 1964. A 42-year-old man with tumor extending to both sides of the mediastinum and (b) containing multiple calcified nodules. This lympho-epithelial thymoma was unresectable. (c) January 1965 and (d) June 1965. Postoperatively 4000 rads tumor dose was given over 27 days and there was progressive decrease in tumor size but the patient died 17 months after diagnosis. Autopsy revealed tumor in the anterior mediastinum, lung parenchyma, and pleura.

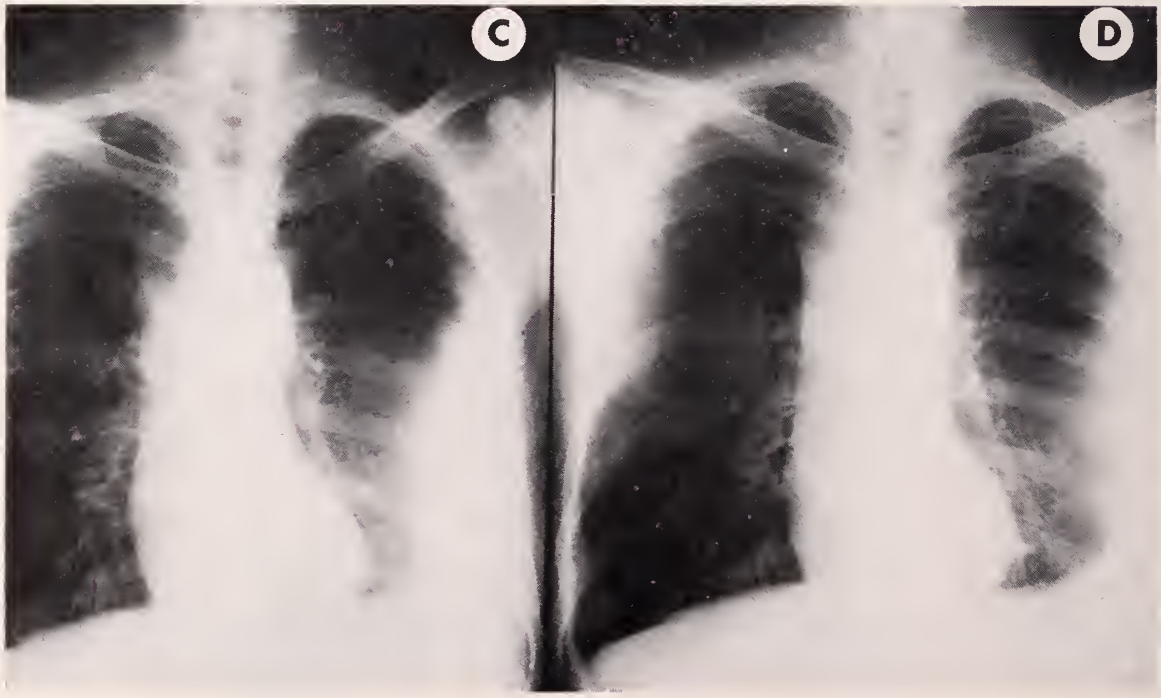

TABLE 3—*Diagnostic studies, therapy and results of 22 cases of thymoma*

Case No.	Age	Sex	Pathology		Symptoms	Roentgen Findings
1	61	F	Lymphocytic	M	Asymptomatic	Right lower anterior mediastinal mass
2	55	F	Lymphocytic	M	MG, 2 years	Widened mediastinum
3	71	M	Spindle	B	Chest pain on left side, cough, dyspnea	Mediastinal mass
4	52	M	Lymphosarcoma	M	Asymptomatic	Anterior mediastinal mass
5	64	F	Spindle	M	Chest pain, cough	Anterior mediastinal mass
6	50	F	Mixed L-E	B	MG, 1 year	Anterior mediastinal mass
7	40	F	Lymphocytic	B	MG, 9 weeks	Anterior mediastinal mass
8	82	M	Lymphocytic	B	Asymptomatic	Anterior mediastinal mass with calcification
9	66	M	Epithelial	M	MG, 5 months	Anterior mediastinal mass
10	38	F	Spindle	M	Asymptomatic	Anterior mediastinal mass
11	71	M	Spindle	B	Cough, dyspnea	Anterior mediastinal mass
12	47	F	Epithelial	M	SVC syndrome	Paratracheal mass
13	42	M	Mixed L-E	M	Peptic ulcers, achalasia, weakness	Anterior mediastinal mass with calcification
14	59	M	Mixed L-E	M	Chest pain, dyspnea	Anterior mediastinal mass
15	57	F	Mixed L-S	B	Chest pain on left side	Anterior mediastinal mass
16	60	M	Lymphocytic	B	MG, 1 month, cough, dyspnea, chest pain	Cystic mediastinal mass with calcification
17	55	F	Epithelial	M	SVC syndrome	Anterior mediastinal mass
18	59	F	Mixed L-E	M	Cough	Anterior mediastinal mass
19	39	M	Mixed L-E	M		Anterior mediastinal mass, mets. pleural effusion
20	43	M	Spindle	M	Chest pain	Anterior mediastinal mass
21	48	F	Lymphocytic	B	MG	Negative
22	42	M	Epithelial	M	Lower extremity weakness	Anterior and central mediastinal mass

M = Malignant. B = Benign. L-E = Lymphoepithelial. L-S = Lymphoid and Spindle Cell.

Case No.	Surgery	Rad. Therapy	Response (cause of death)	Survival	
1	Complete removal	3000 rads	Doing well	50 mos.	A
2			Dx at autopsy (MG crisis)	8	D
3	Complete		Improvement (MI–CHF)	145	D
4	Biopsy	3056 rads	Improvement	104	A
5	Incomplete	2000 R a	Improvement	144	A
6	Complete		Improvement (MG)	142	D
7	Tracheostomy	2600 rads treated elsewhere	No improvement (MG crisis)	2	D
8	Complete			7	D
9	Complete	3000 rads	Improvement	60	D
10	Complete	2024 rads	Doing well	108	A
11	Complete		Improvement (Ca stomach)	4	D
12	Tracheostomy, Bx	6000 rads mult. courses	Sl. improv. after each rad. course but progr. decline	28	D
13	Biopsy	4000 rads	Improv., decrease in mass. Resid. tumor at autopsy	17	D
14	Complete	2000 rads treated elsewhere	Improvement	Lost	
15	Complete		Improvement	37	A
16			Dx at autopsy (MG crisis)	3/4	D
17	Biopsy Postrad. thoracot. no resid. tumor	4150 rads	Improvement (MI)	14	D
18	Incomplete	5000 rads	Improvement except for (Pneumonia)	5	D
19	Thoracot. elsewhere	6535 rads mult. courses	Improv. with each course. Resid. tumor with intrathoracic spread	29	D
20	Incomplete	4000 rads	Improvement	33	A
21	Complete		Improvement	26	A
22	Incomplete		Progressive decline	1	D

A = Alive. D = Died. MI = Myocardial Infarction. CHF = Congestive heart failure.

Pathology

In thymomas the normal cellular architecture is distorted by overgrowth of epithelial cells, lymphocytes and at times spindle cells. These spindle cells occur in whorls and are thought to represent elongated epithelial cells.[5] There is usually absence or marked decrease in the number of Hassall's corpuscles and very little pleomorphism of cells. Review of multiple sections of the tumor may show quite varied patterns but an overall evaluation appears to make it possible to classify tumors into four groups according to predominant cell type as has been done by Bernatz and others at the Mayo Clinic,[4] i.e., predominantly epithelial (Fig 6), lymphocytic (Fig 7), spindle cell (Fig 8), or mixed (Fig 9) tumors. Six tumors were classed as 'mixed' indicating nearly equal distribution of two cell types. The mixed tumors consisted of lymphocytic and epithelial in five cases and lymphocytic and spindle cell in one case. Using this classification we found the distribution shown in Table 4.

In the case diagnosed as lymphosarcoma the microscopic picture was characteristic. The tumor was definitely believed to have arisen in the thymus. Almost 10 years after successful surgery and postoperative radiotherapy there has been no evidence of devel-

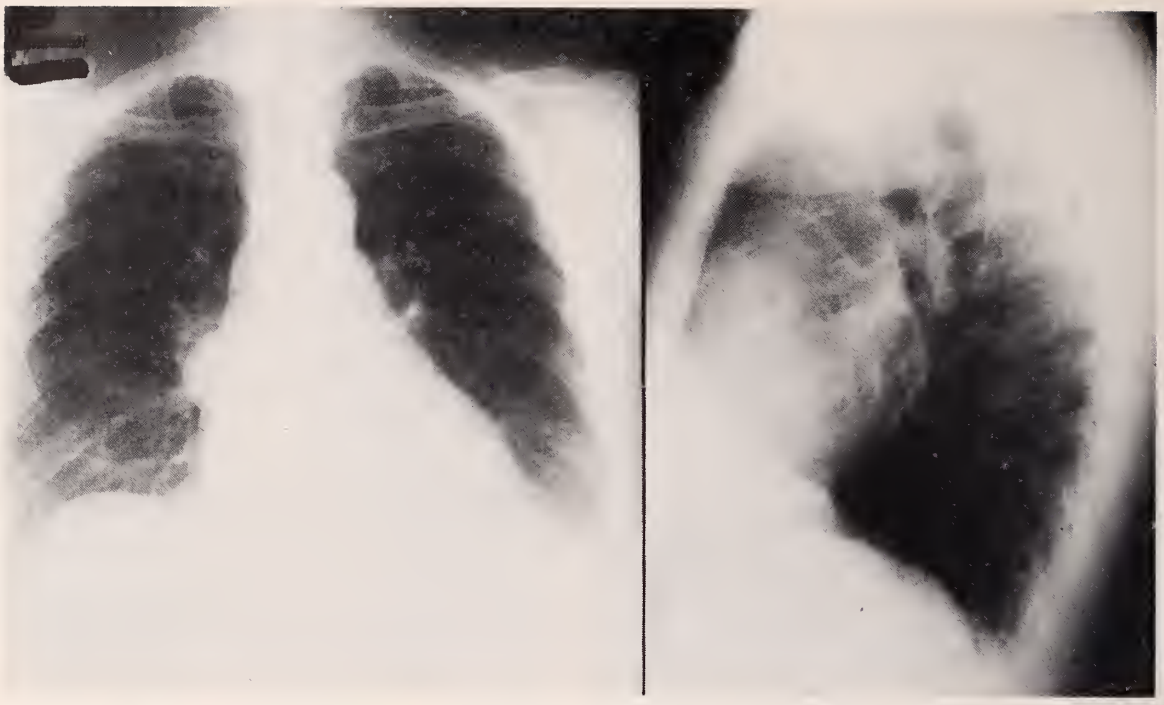

Fig. 3—Asymptomatic 61-year-old woman with an invasive lymphocytic thymoma. Surgical removal and postoperatively 3000 rads to the mediastinum over 22 days. Patient alive and well four years later.

Fig. 4—A 59-year-old woman with an invasive, mixed thymoma who had incomplete removal and received 5000 rads tumor dose postoperatively over 32 days. Patient died of intercurrent disease five months postoperatively.

TABLE 4—*Distribution of tumors*

Lymphocytic	6
Epithelial	4
Spindle cell	5
Mixed	6
Lymphosarcoma	1
Total	22
Tumors associated with myasthenia gravis	
Lymphocytic	4
Epithelial	1
Mixed	1
Total	6

opment of lymphosarcoma elsewhere in the body.

There was no association between spindle cell tumors and MG. The low incidence of this combination has been reported by others.[4-6] Also it was not possible to predict which patients had MG from the microscopic appearance of the tumors.

Unless there is some evidence of normal

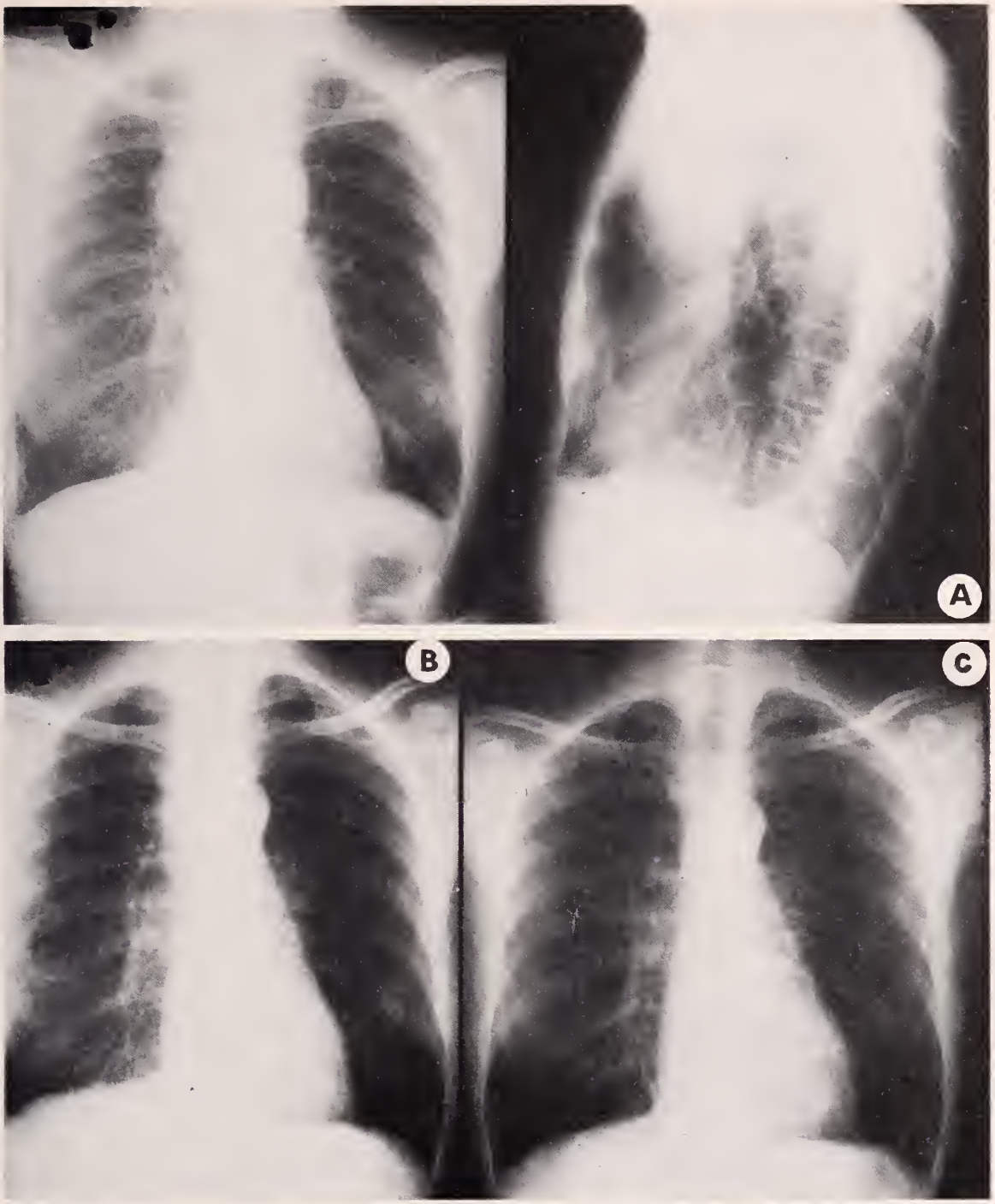

Fig. 5—(a) April 1964. A 55-year-old woman with SVC syndrome was found to have an epithelial thymoma which was invasive and unresectable. She received 4150 rads tumor dose over 27 days. Three months after completion of x-ray therapy a second thoracotomy revealed no residual tumor. (b) June 1964. Decrease in size of tumor after radiation. (c) September 1964. No evidence of mediastinal tumor.

underlying thymic architecture such as the septa separating lobules, it may be impossible to establish the tumor as arising in the thymus. Four of our original cases were actually mediastinal lymphosarcoma or reticulum cell sarcoma. Other tumors may spread to the mediastinum simulating a thymic tumor such as Hodgkin's disease, seminoma, and metastatic malignant neoplasms.[7]

Another problem is determining malignancy or benignancy. The lack of cellular anaplasia may make this differentiation impossible microscopically and it may be best determined at surgery. An encapsulated tumor often lies in contact with pericardium or pleura, but if the capsule remains intact it can generally be removed without great difficulty. Capsular invasion indicates malignancy and often presents a greater problem surgically since tumor may surround and compress vital vascular structures and produce SVC syndrome. This was true in two cases.

Myasthenia Gravis

In 1901, Wiegert[8,9] first observed the association of thymoma and MG in a postmortem examination of a myasthenic patient. The first recorded successful removal of a thymoma from a myasthenic patient was done in 1936 by Blalock.[9] In the 1940s thymectomy became an accepted form of treatment of patients with MG. There has been controversy over the effectiveness of this operation in improving or completely relieving MG, but several studies have revealed certain important facts.

Patients with moderate to severe disease are the best candidates for thymectomy, and the shorter the duration of MG the better chance of improvement following surgery. In cases where the disease has been present for more than five years surgery is much less effective.

MG is slightly greater in occurrence among females. Seventy-five percent of females develop the disease prior to age 35 while just the opposite percentage is found in males. The best responses have been seen when thymectomy was performed in females below the age of 35.

Viets and Schwab[10] demonstrated 65% improvement or complete remission following thymectomy in cases where there was no tumor and an even better remission rate in patients who received preoperative radiation. Keynes' patients showed a 70% response.[9] In the presence of thymoma the MG patient has a much worse prognosis in spite of thymectomy, radiation or the use of drugs. Although malignancy occurs in a significant number of thymomas, most patients die of complications of MG before malignant spread is fatal.

Various reports indicate approximately 15% to 20% of patients with MG have thymomas while 50% to 75% of thymomas are associated with MG.[6,9,11,12] Only 6 of our 22 patients with thymomas had associated with MG (27%). During the same period 74 patients at the University Hospitals were diagnosed as having MG, i.e., 9% of patients with MG had thymomas.

None of our patients received preoperative radiation. In three of our six cases thymoma was diagnosed at autopsy although anterior mediastinal tumors were evident on x-ray studies. Two patients were doing quite poorly with increased resistance to medication, but because of severe symptoms surgery was not performed. Both died in crises. One patient, a 60-year-old man, died three weeks after diagnosis and had a benign thymoma. The other patient, a 55-year-old woman died more than one year after the diagnosis of MG and an invasive tumor involving the right upper lobe and pleura was found.

In the third case, a 40-year-old woman, there was progressive decline to death in two months. This patient received approximately 2600 rads to the mediastinum at another hospital but there was no improvement in symptoms.

In the other three cases surgery was performed and one received postoperative radiation therapy because the tumor, although felt to be completely removed, was malignant. This patient received 3000 rads and had improvement in symptoms with decrease in medication. He survived five years; cause of death—unknown.

The other two operated cases revealed benign tumors. In a 50-year-old woman the entire tumor was removed and the patient had considerable improvement with decrease in medication. This patient died 12 years later of MG. The remaining patient, still alive 26 months after diagnosis of MG, was operated on because of increased medication requirements, and an 18-gm thymoma was found. X-ray studies had been negative. Postoperatively the patient has been doing well with decrease in medication.

In the first three patients mentioned, two females and one male, the course of MG was rapidly progressive, unimpeded by any form of therapy. In the latter three cases, two females and one male, all showed response to surgery and surgery plus radiation. The two who died lived considerably longer than is usually the case in MG associated with

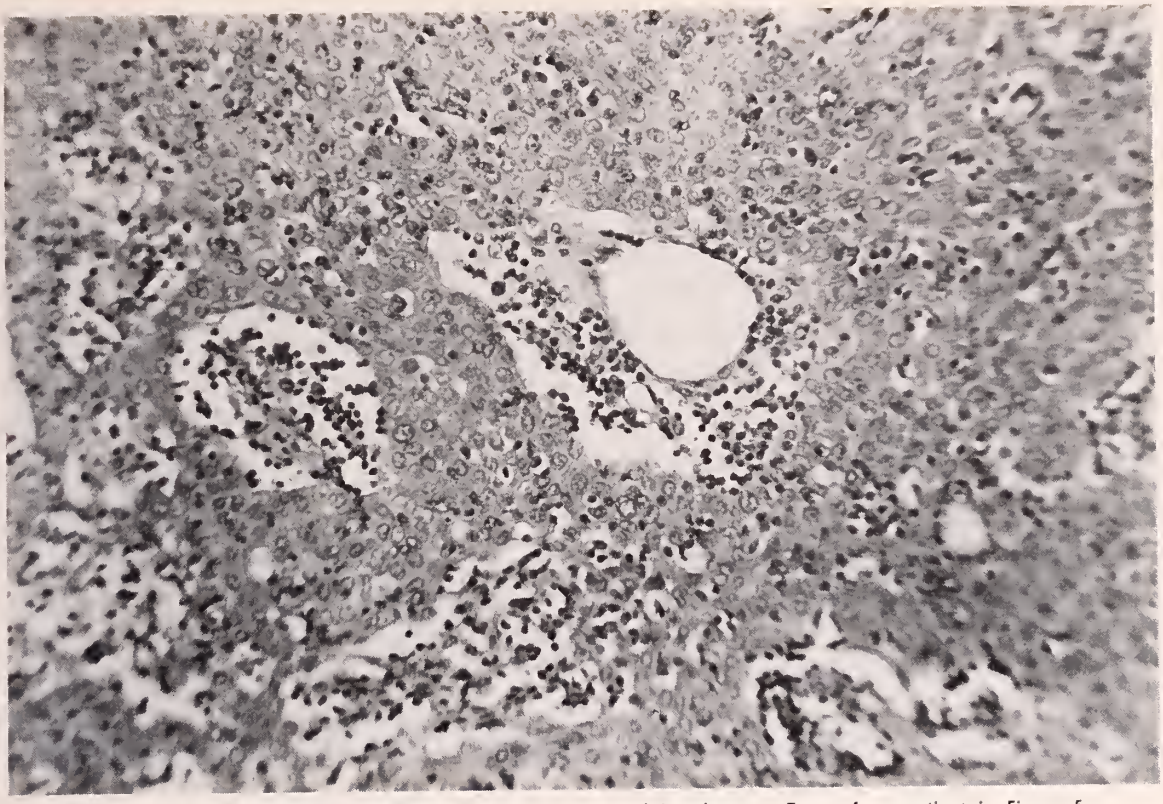

Fig. 6—A predominantly epithelial thymoma with scattered lymphocytes. Tumor from patient in Figure 5.

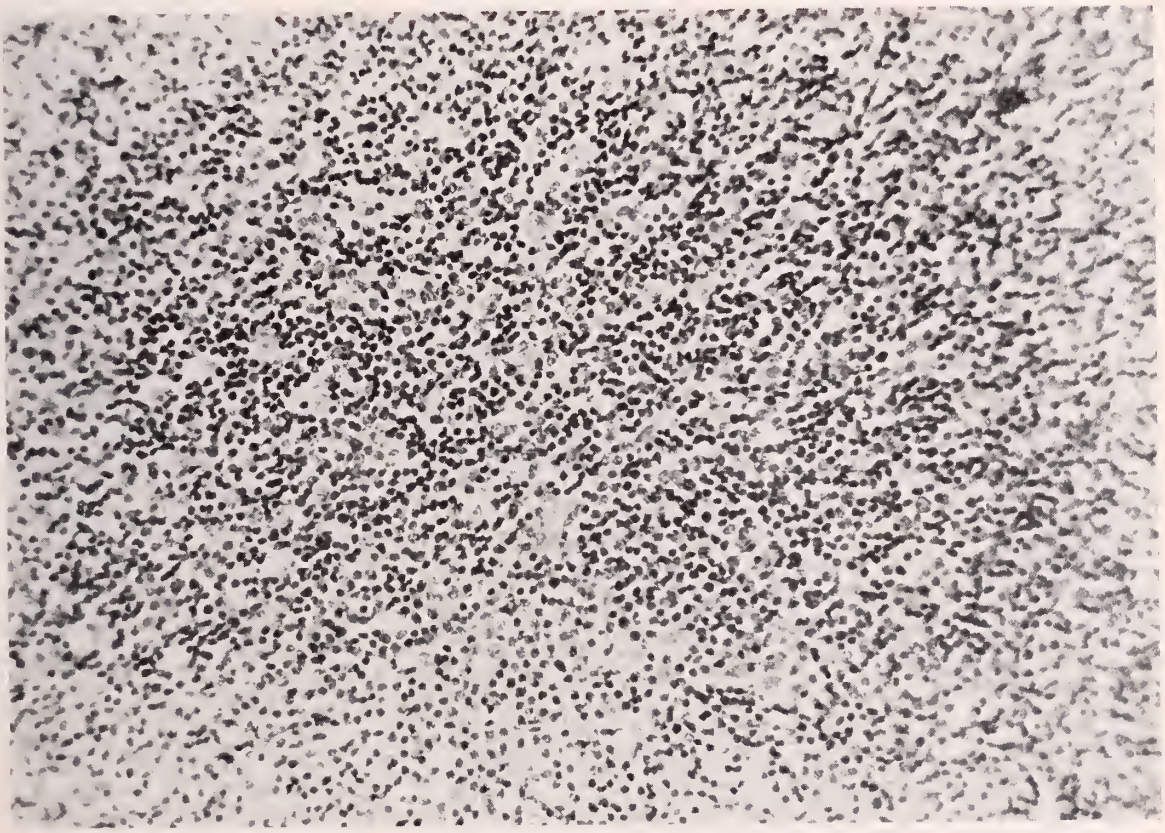

Fig. 7—A predominantly lymphocytic thymoma with occasional epithelial cells. Tumor from patient in Figure 3.

thymoma. It is not possible to evaluate the effect of radiation in the case in which it was used postoperatively since the tumor was believed completely removed.

Results

Benign Tumors

The six patients with well-encapsulated, noninvasive tumors who underwent thymectomy responded well. Five of the six presented with symptoms which subsided postoperatively. None had recurrence of tumor. Four of the six have died, one 50-year-old woman with MG 10 years later, a 71-year-old man with a myocardial infarction 10 years later, and a 71-year-old man with carcinoma of the stomach four months after diagnosis. A fourth patient, an 82-year-old man, was reported to have died seven months after diagnosis but the cause was unknown. Two patients remain alive, a 48-year-old woman at 26 months and a 57-year-old woman at 37 months after diagnosis.

There were two other patients in whom benign thymomas were found at autopsy; both had MG.

The eight patients with benign tumors had the predominant cell types shown in Table 5.

TABLE 5—*Predominant cell types*

Lymphocytic	4
Spindle cell	2
Mixed	2

Malignant Tumors

The 14 patients with invasive tumors showed a more varied course. The histology of the tumors is shown in Table 6.

TABLE 6—*Tumor histology*

Epithelial	4
Lymphocytic	2
Spindle cell	3
Mixed	4
Lymphosarcoma	1

Tables 5 and 6 indicate that predominant cell type is not a guide to benignancy or malignancy.

The extent of therapy is shown in Table 7.

TABLE 7—*Extent of therapy*

Complete removal—post-operative radiation	3
Incomplete removal—post-operative radiation	4
Incomplete removal—without post-operative radiation	1
Biopsy only and radiation	5
Diagnosis at autopsy	1

Although the tumors were believed to be completely removed in three cases, postoperative radiation therapy was given because of the grossly invasive character of these lesions. A 61-year-old, asymptomatic woman with a predominantly lymphocytic tumor received 3000 rads to the mediastinum over 22 days (Fig 3). She is alive and doing well 50 months after diagnosis. A 66-year-old man with MG also received 3000 rads over 25 days for a primarily epithelial tumor. He responded well with decrease in symptoms of MG and died 60 months later from an unknown cause. A woman, 38 years old, with a spindle cell tumor received 2024 rads over 14 days and is alive and well nine years later (Fig 1).

Of the four patients who had incomplete surgery and postoperative radiation three responded well and two of these are still alive. A 64-year-old woman with a spindle cell tumor received only 2000 R/a* over 10 days and is alive and well more than 10 years later. A second patient doing well 33 months after diagnosis is a 43-year-old man with a spindle cell tumor who received 4000 rads over 25 days. He has had complete relief of his presenting chest pain. Another patient in this group who responded well was a 59-year-old woman with a mixed tumor who received 5000 rads to the tumor over 32 days (Fig 4). She died five months later of pneumonia. One patient with incomplete removal received radiation elsewhere but has been lost to follow-up.

In five patients the tumors were so invasive that excision was not attempted and only biopsy was performed. Postoperative radiation was given in each case and these allow the best evaluation of the effectiveness of radiation therapy.

The best response was seen in a 55-year-old woman who presented with SVC syndrome. Biopsy revealed a predominantly epithelial tumor and the patient received 4150 rads to the mediastinum in four weeks. Symptoms subsided and roentgenograms revealed progressive decrease in the mediastinal tumor (Fig 5). A thoracotomy performed four months later showed no evidence of residual tumor. This patient died 14 months after diagnosis of myocardial infarction. This case demonstrates complete destruction of a thymoma by radiation therapy. The fact that this tumor was predominantly epithelial is even more interesting since the epithelial cell is a more radioresistant cell than the lymphocyte. Williams[8] in England has reported similar results with

* R/a = Roentgens in air.

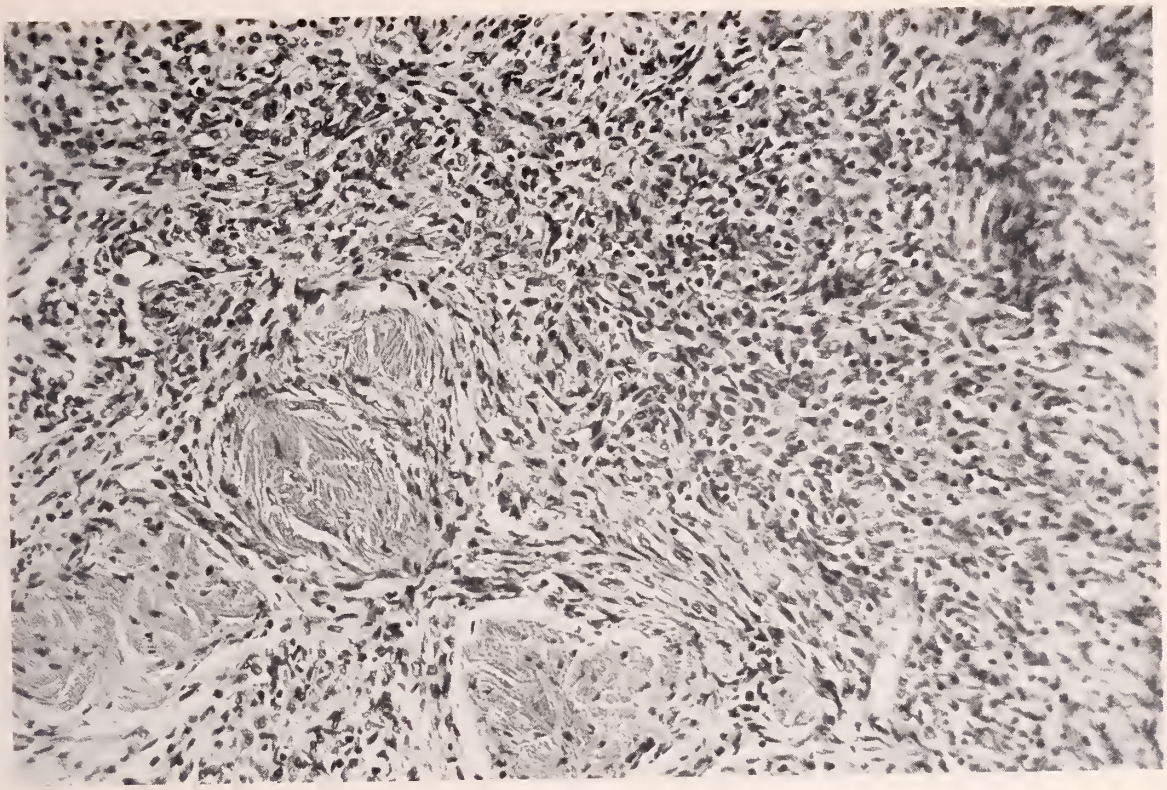

Fig. 8—Section of the predominantly spindle cell tumor of the patient in Figure 1.

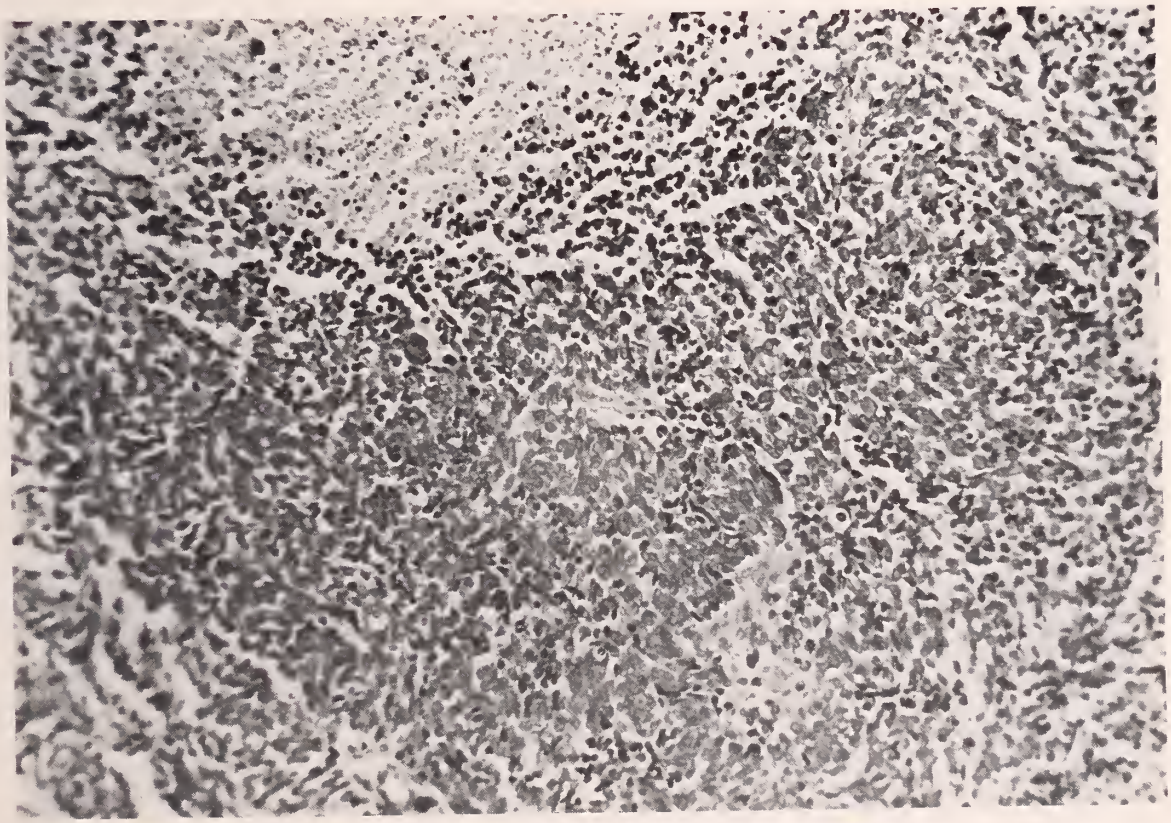

Fig. 9—An example of a mixed tumor with lymphocytes and epithelial cells.

predominantly epithelial tumors at this dose.

Another case in which the tumor could only be biopsied was a mixed lymphoepithelial tumor occurring in a 42-year-old man with no definite chest symptoms. He received 4000 rads to the tumor in four weeks. While x-ray studies showed progressive decrease in the mediastinal mass the patient's condition became worse and he died 17 months later. Autopsy revealed cardiorespiratory failure secondary to compression of the great vessels in the mediastinum by invasive tumor.

A third patient, a 52-year-old man, had lymphosarcoma of the thymus. He was asymptomatic but an anterior mediastinal mass was revealed on routine chest roentgenogram. Because the tumor was found to be adherent to the great vessels at thoracotomy only biopsy was performed. A tumor dose of 3056 rads in three weeks was given. Follow-up chest films showed the tumor to have completely disappeared. Almost nine years later the patient is asymptomatic with no evidence of recurrence of lymphosarcoma elsewhere in the body. This excellent response could be predicted because of the very radiosensitive nature of the lymphocytes.

Two other patients had invasive tumors with evidence of metastases beyond the tumor, a 38-year-old man with metastases elsewhere in the chest and a 47-year-old woman with supraclavicular node involvement. The former had a predominantly epithelial tumor, the latter a mixed lymphoepithelial tumor. Both were given multiple courses of radiation totaling over 6000 rads over a period of several months. Both patients initially responded with some improvement in symptoms and decrease in anterior mediastinal masses, but metastases could not be controlled. The man died 29 months after diagnosis and the woman at 28 months. In both cases the initial course of radiation was limited because of complications. In the man who was treated with 5-FU there was a marked leukopenia and the woman developed an infected tracheostomy and pneumonia so radiation was discontinued until these symptoms improved.

Discussion

Thymomas are generally slow growing tumors which may be present for years causing no symptoms or such nonspecific complaints as cough, chest pain, and dyspnea. Routine chest x-ray films in most cases will reveal a mass in the anterior mediastinum of variable size and configuration, sometimes well defined but more often irregular and occasionally containing an amorphous collection of calcium in part of the tumor. Small lesions may require additional views and with the clinical history of MG these should always be obtained.

It does not appear from our series that benignancy can be differentiated from malignancy radiographically or in fact that thymoma can always be separated from substernal thyroid, teratoma or lymphomas as evidenced from several of our cases.

Thoracotomy is necessary for tissue diagnosis and the sternal splitting approach is usually the most successful technique. Surgery should consist of complete excision which is usually possible if the tumor is well encapsulated. In these cases prognosis is good. If the tumor is incompletely removed or if only biopsy is performed, postoperative radiation should be given. The course in patients with invasive tumors is quite variable as demonstrated by our cases as well as many other series reported in the literature.[6, 8, 13]

In those cases in which there was incomplete removal and postoperative radiation the patients generally did well. In the instances where tumors were invasive and there were metastases to lungs, pleura, or cervical nodes prognosis was poor and the tumor was not controlled.

The effectiveness of radiation could best be determined in five cases where surgical removal was impossible and only biopsy was performed. The predominantly epithelial tumor which received the same dose as a comparably sized mixed lympho-epithelial tumor and responded much better, suggests that factors other than cellular radiosensitivity alone are involved. Unfortunately, we do not have a larger series of patients treated with radiation alone. The two cases which showed only slight improvement with multiple courses of radiation developed early metastases. Complications prevented administration of adequate radiotherapy.

We believe that in cases where capsular invasion is diagnosed and residual tumor is left or in cases where only biopsy is possible, the patient should receive at least 4000 rads to the mediastinum using supervoltage or cobalt teletherapy. The rate of radiation

administered should be 1000 rads per week.

It may be that the best approach to large, invasive tumors is one similar to that used in our case No. 17. Initially thoracotomy was performed to determine the diagnosis and then a course of radiation consisting of 4000 rads tumor dose was given over a four-week period. Serial postradiation chest x-ray studies would be a guide to tumor response and a second thoracotomy could be performed with the prospect of removing the shrunken tumor. Three of our patients are known to have died from the effects of their tumor. We must assume with Effler and McCormack[13] that all thymomas have malignant potential and, therefore, deserve aggressive therapy.

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OCCUPATIONAL HEARING LOSS—RECENT TRENDS AND PRACTICES

MEYER S. FOX, M.D., Milwaukee, Wis.: *Industrial Medicine & Surgery*, pp. 204–208 (Mar) 1968

This paper on occupational hearing loss was presented before the 53rd Annual Convention of the International Association of Industrial Accident Boards and Commissions, Portland, Me., Sept. 20, 1967. The various types of occupational hearing loss, their causes and clinical manifestations were described. Also how the hearing ability of the worker was measured, the instruments used and how the test results were equated in terms of hearing impairment as required under the compensation acts of the various states and Provinces of Canada. Particular attention was directed to the hearing loss which may follow blows to the head, with or without fracture, whiplash injuries of the neck, blasts, explosions and Noise-Exposure. Dr. Fox emphasized the importance of the hearing studies made at the Wisconsin State Fair in 1954 and 1955 and the approach to the hearing loss problem by the Wisconsin Industrial Commission. The principles and guidelines developed by the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology[1] are described and recommended for the prevention of hearing loss in industry.

A survey was originally made of the Comparative Provisions of Occupational Hearing Loss in the United States and Canada in 1963.[2] This survey was recently updated[3] and revealed a definite trend on the part of Industrial Commissions and state agencies to recognize and provide greater coverage for noise induced hearing loss. The various statutes now include methods for evaluating hearing impairment, compensation for tinnitus and provision for a hearing aid.

The author emphasized that the occupational hearing loss problem is not a static one. While more states are recognizing noise induced hearing loss, it is constantly being reappraised. The various relationships of acoustic trauma, of noise exposure, hearing impairment, protective measures, etc. all are being tested and reviewed. In addition to the medical problems, certain changes are taking place because of social, economic and political demands.

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Evisceration of Bowel Through the Vagina Following Irradiation for Cervical Carcinoma

Report of First Known Case

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■ BOWEL EVISCERATION following vaginal surgery is possible; however, no reports of bowel evisceration through the vagina following radium therapy, and/or irradation by x-ray or cobalt teletherapy, either vaginally or trans-abdominal, for carcinoma of the uterus, could be found in the literature. The first recorded or known case of spontaneous bowel evisceration through the vagina following such therapy is presented below.

Case Report

On Feb. 13, 1961, this white widow, age 49, was admitted to the hospital because of uterine bleeding of six days duration following amenorrhea of five years. A urinalysis test was normal, complete blood count and blood components were normal, chest x-ray film was normal, and the syphilis (VDRL) microflocculation test was negative. Cervical biopsy and curettage were performed the following day. The pathologic diagnosis was infiltrating squamous cell carcinoma of the cervix, grade II, and atrophic endometrium. Clinically the carcinoma was stage I.

A week later, employing the Ernst applicator, 65.5 mg of filtered radium was applied to the cervix, uterine cavity, and vaginal vault for a dosage of 3078.5 mg hours. Sixteen days after the first application, again employing the Ernst applicator, 50.5 mg of filtered radium was applied to the cervix, uterine cavity, and vaginal vault for a dosage of 1818.0 mg hours.

Beginning another 12 days later external cobalt teletherapy was administered over a period of 32 days. Fifteen x 15 cm fields were irradiated anteriorly and posteriorly with a 4 cm strip blocked out in the midline. A combined, or grand total, dosage delivered was as follows: cervix—12,425 r, point A—7,300 r, point B—6,257 r.

Examination six weeks later showed no skin reaction, and no diarrhea followed. The cervix could not be visualized by speculum, and no pelvic mass was palpable by bimanual or rectal examination. No fistulae were present. The patient was regarded as in excellent post-irradiation condition.

She was seen at three-month intervals the first year after therapy, and at six-month intervals thereafter for two years. The findings were atresia of the vaginal cavity and vault at the last examination.

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Six years later, on July 7, 1967, the patient was seen at her home about 1:30 a.m. While she was straining at stool, 18 inches of small bowel eviscerated through the vagina. Manual reduction was easily accomplished by elevating the pelvis. She was transferred to the hospital by ambulance, and the vagina was packed with iodoform gauze after a preliminary Papanicolaou vaginal vault smear. This smear was negative for malignant cells. Foley catheter bladder drainage, continued Trendelenburg bed position, liquid regimen, and penicillin therapy were instituted. No peritonitis developed. The urine was normal; chest x-ray films were normal; and chemical blood survey was all within normal range. Cystogram and intravenous pyelograms were normal.

One week later a repeated vaginal vault Papanicolaou smear was negative for malignant cells. A high posterior colporrhaphy and partial vaginectomy were performed under spinal anesthesia, allowing only an anterior vaginal drainage passage to admit a No. 16 French catheter the entire length of the vagina. No uterus, mass, or bleeding was present at the upper vaginal vault. Primary healing occurred. Microscopic examination of the vaginal mucosa did not show any malignancy, only "mild inflammatory changes." The patient was discharged ambulant ten days later. Thirty days later (40 days after surgery) a vaginogram, employing a Foley catheter and opaque medium technic, showed a healed and closed vaginal vault. No vault sinuses, pockets, or pelvic extravasations were present.

Discussion

The necrosis caused by irradiation seems to be a progressive avascular necrosis causing tissue disintegration. When the irradiation dose is excessive, and especially when the individual is hypersensitive to irradiation, this avascular necrosis may occur even years after the therapy. Irradiation therapy can cause a sclerosis of the blood vessels adjacent to the area treated and this ischemia then can cause the local degeneration years later. Vesico-vaginal fistulae developing up to 37 years after radium treatment of cervical carcinoma have been reported following chronic ulcerative cystitis.[1-4] The complication of evisceration through the vagina has not been encountered by Kottmeier at the Radium Hemmet.[5]

It is felt that the irradiation dose was within the range usually employed. The opin-

ion is held that she has been cured of her cervical carcinoma since two Papanicolaou smears and excised vaginal mucosa were negative for carcinoma six years after therapy.

Summary

An unusual case of post-irradiation (for cervical carcinoma) small bowel evisceration through the vagina is presented. Factors of delayed progressive irradiation ischemic disintegration and destruction of the uterus and vaginal vault plus straining at stool possibly developing this complication are presented. We have been unable to find a previous report of a similar complication following irradiation therapy for squamous cell carcinoma of the cervix. The correction of the defect by vaginal surgery was successful.

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Intravenous Lidocaine Anesthesia in Surgery of the Extremities

Report of Fifty Cases

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■ WHEN THE GENERAL HEALTH status of a patient or a recent meal by a patient precludes the use of general anesthetic for surgery in an extremity, several alternate methods of anesthesia are available. In the upper extremity these methods include local infiltration of the anesthetic agent, local nerve block, axillary nerve block, brachial plexus block, and intravenous lidocaine (Xylocaine) in a closed vascular system. This report will discuss the use of intravenous lidocaine.

Intravenous lidocaine in a closed vascular system has proved useful in a large variety of surgical procedures in the upper and lower extremities. In general, this method of anesthesia may be used in any procedure where a tourniquet at mid-arm or thigh can be utilized and the total procedure time does not exceed two hours. It has the advantages of being safe, effective, and requiring no technical skill other than inserting a needle into a vein.

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In 1908, Bier[1] described the use of intravenous lidocaine to obtain regional anesthesia. Four years later he had performed 375 procedures, using this method, without any complications. After a brief period of popularity the method fell into disuse, there being but few reports published in the last 50 years to either champion or condemn its use. Only recently has there been a revival of interest in this method of regional anesthesia.[2-5]

Materials and Methods

The equipment necessary include a conventional pneumatic tourniquet, a 50-ml syringe, a 21-gauge needle, a length of intravenous tubing 18 inches long, and an elastic bandage. Lidocaine, 0.5%, is the only medication required (Fig 1). The pneumatic tourniquet is placed around the arm midway between the shoulder and elbow. A 21-gauge needle, connected to the 50-ml syringe via the length of tubing is inserted into a vein distal to the uninflated tourniquet. The extremity distal to the tourniquet then is exsanguinated by compression using the elastic bandage, care being taken not to dislodge the needle. With the compression bandage still in place, the tourniquet is inflated to 275 mm of mer-

Fig. 1—Equipment necessary for intravenous lidocaine in a closed vascular space: Fifty-milliliter syringe, 21-gauge needle with extension tube, 50 ml lidocaine 0.5%, elastic bandage to exsanguinate extremity, pneumatic tourniquet.

cury pressure. The compression bandage is removed. Fifty milliliters of 0.5% lidocaine then is injected into the emptied vascular system of the extremity. Following injection of the lidocaine the needle is withdrawn from the vein. Anesthesia is usually complete within 5 to 10 minutes. During this time the extremity is prepared with a surgical soap and draped with sterile sheets.

A local ring block using 1.0% lidocaine, injected subcutaneously beneath the area over which the tourniquet will lie, will reduce the discomfort produced by the inflated tourniquet. Another solution to the tourniquet discomfort which sometimes occurs is the use of two tourniquets. In this method the first tourniquet is placed around the upper arm and anesthesia achieved as previously. Following the injection of the lidocaine a second tourniquet is placed distal to the first, around the lower humerus, but not inflated. The extremity then is prepared and draped. If, during the procedure, the patient complains of tourniquet discomfort the distal tourniquet, which overlies an anesthetic area, is inflated and the proximal tourniquet is released. Premedication with a barbiturate and meperidine or morphine is most helpful.

The method for the lower extremity is similar. The tourniquet is placed at the mid-thigh level and, because of the increased volume of the vascular tree of the leg, a larger quantity of lidocaine must be used. One hundred milliliters of 0.5% lidocaine have given complete anesthesia in the few procedures in which this method was utilized in the lower extremity.

Results

This method of anesthesia was utilized for 50 surgical procedures. In 44 patients the procedures involved the hand or forearm and in the remaining 6 patients the operations were performed on the foot and leg. It was equally effective in skin, bone, tendon, or nerve procedures. A list of the type of procedures performed using this method is listed in Table 1.

TABLE 1—*Categories of cases*

Fasciectomy (Dupuytren's Contracture)	12
Synovectomy and Arthroplasty (Rheumatoid Arthritis)	6
Excision Tumors Hand and Feet	12
Revision Amputation Digits	5
Tendon Repairs	4
Reduction Fracture	2
Bone Grafts and Arthrodesis	5
Abscess Hand	2
Carpal Tunnel Syndrome	2
TOTAL	50

In all procedures of the upper extremity the onset of anesthesia was immediate, and complete anesthesia was obtained within 10 minutes, in all patients. In the lower extremity the results were similar with the exception of the first patient on whom the method was tried. In this case because of an insufficient quantity of lidocaine the anesthesia obtained was somewhat patchy and incomplete. Local infiltration of lidocaine was used to supplement the anesthesia.

The duration of the surgical procedures varied from 15 to 168 minutes, with the mean being about 55 minutes. The duration of the anesthesia was adequate except in those cases where the surgery time exceeded two hours. In those cases in which the time exceeded two hours analgesia was supplemented by the local infiltration of lidocaine. The completeness of anesthesia was constant throughout all procedures. Upon release of the tourniquet the patients regained sensation and muscle control in the extremity within 5 minutes in all cases.

There were no untoward reactions to the medication in any patient. Ten patients complained of discomfort in the region of the tourniquet but in only one was the pain severe. The tourniquet discomfort was relieved by inflating the lower tourniquet, which was over an anesthetized area, then deflating the proximal tourniquet.

The only difficulty encountered using this method was attributable to the location of the two tourniquets on the arm. When two tourniquets are used neither is in the optimal location, the mid-arm level. In 3 patients there was evidence of venous congestion in

the hand toward the end of the procedure. In one patient the tissue staining due to venous congestion was sufficiently marked to hinder surgical dissection. This complication was not encountered in the lower extremity.

Comment

The results of intravenous lidocaine anesthesia have been most encouraging. We have used it in preference to axillary or brachial block anesthesia because of its ease in administration, rapidity, completeness of action, its relative safety as compared to brachial block, and the lack of technical proficiency needed for administration. All that is required technically is the insertion of a needle into an arm or leg vein. In addition to the above advantages, the pneumatic tourniquet provides the advantages of a bloodless field. This method of anesthesia has proved useful in patients for whom a general anesthetic would have been contraindicated, such as poor risk patients, patients with severe pulmonary disease, or patients who have eaten too recently to be safely put to sleep.

The disadvantages of this procedure are: (1) the pain produced by the inflated tourniquet, (2) the tourniquet cannot be deflated either purposely or accidentally without loss of anesthesia, (3) it cannot be used for procedures above the elbow or above the lower one-third of the thigh, and (4) two hours is the maximal time limit for which, we feel, this method should be used. This method should not be used in patients with peripheral ischemic vascular disease or in those with an active infection near the site of injection.

In order to prevent the rapid escape of lidocaine into the general circulation, we have chosen not to release the inflated tourniquet after injection of the lidocaine for at least 15 minutes. This time limit allows most of the lidocaine to diffuse into the tissues of the extremity and not escape into the general circulation when the tourniquet is released.

Summary

Intravenous lidocaine in the closed vascular system of the forearm and leg is an effective, easy to administer, and safe method of anesthesia. This method of anesthesia was used in 50 patients without serious side effects. The technic of administration is described and the results listed. This method of anesthesia is especially useful in the poor-risk patient and has been found preferable to axillary or brachial block in most instances.

TABLE 2—*Summary of surgical procedures*

Age of Patients	Average: 49 years Range: 16–76 years
Amount of Lidocaine	Upper Extremity (44 patients) 250 mg Lower Extremity (6 patients) 600 mg
Duration of Surgery	Average: 55 minutes Range: 15 168 minutes
Duration of Tourniquet Application	Average: 69 minutes Range: 15–180 minutes
Effectiveness of Analgesia	Total: 48 cases Partial: 2 cases

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PARABEN SENSITIVITY: SUBTLE TROUBLE

STEPHAN EPSTEIN, MD, University of Wisconsin Medical School, Madison, Wis.: *Ann Allerg* 26:185–189 (Apr) 1968

Parabens are preservatives used in numerous pharmaceutical and cosmetic preparations and foods. Although in general these chemicals are very innocuous, allergy to them causes a contact dermatitis that often is insidious and unrecognized. Three cases of paraben sensitivity are presented. One is an example of the insidious, readily overlooked form that unfortunately is often permitted to develop into a generalized, disabling, and miserable dermatitis. The other two demonstrate acute contact dermatitis caused by parabens. Patients allergic to parabens often also have strong contact sensitivities to other agents especially topical medicaments. This may mislead the investigating physician in regard to the real cause.

Physicians should become more aware of paraben sensitivity, especially in patients who claim that almost every cream or ointment they have used is irritating. These patients are not necessarily neurotics or endowed with an irritable skin but may be allergic to the parabens.

HEREDITARY HEMATURIA

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■ IN 1902 GUTHRIE reported persistent and apparently asymptomatic hematuria in several members of an English family under the title of "Congenital, Hereditary and Family Hematuria."[1] Continued observation of the same family by Kendall and Hertz[2] in 1912, Hurst[3] in 1923, and Alport[4] in 1927, corroborated the persistent hematuria and the genetic background and showed the syndrome to have serious import in some instances, especially in male members of the family. Twenty-one similar families have been reported since that time with an impressive incidence of extrarenal manifestations including auditory, ocular, neurological, and cardiac abnormalities, and a significant mortality among the males due to glomerulonephritis or pyelonephritis.[1-26] We wish to record another family with this affliction and to emphasize the importance of including this syndrome in the differential diagnosis of persistent unexplained hematuria. Among the 28 members in three generations of our family who were available for study, 11 have been affected. Two have died of nephritis and four have variable degrees of deafness (Fig 1). Two have been studied carefully and are presented here.

Case Reports

Case 1 (Fig 1). A married 40-year-old white woman of Greek descent had persistent microscopic hematuria for at least eight years. Except for measles, mumps, chicken pox, and a mastoidectomy she had been in good health. She had four uncomplicated pregnancies. There was no history of rheumatic fever, streptococcal sore throat, nephritis, or kidney stones. At the age of 32 the patient had an illness characterized by weakness, headache, splenomegaly, and jaundice, all of which cleared without a definitive diagnosis. Shortly following this illness, she experienced back pain and passed grossly bloody urine. An intravenous pyelogram at that time showed questionable narrowing of a segment of the right ureter, but cystoscopy and retrograde pyelography with dilatation of the right ureter failed to provide findings adequately explaining the hematuria. Since that time, she has experienced episodes of chills, fever, back pain, and pyuria at approximately six-month intervals. Microscopic hematuria has persisted throughout and led to numerous evaluations of the genitourinary tract, including retrograde pyelography and repeated dilatations of the ureter. In the past five years the patient has complained of intermittent arthralgia and painful tingling paresthesia of the arms and legs.

Positive physical findings included bilateral mastoidectomy scars and a Grade I systolic murmur along the left sternal border.

Laboratory studies have shown normal blood counts, serology, blood sugar, blood urea nitrogen, creatinine, liver function (BSP), calcium, phosphorus, alkaline phosphatase, uric acid and electrolytes. The blood pH on one occasion was 7.47. L.E. preparations and tests for C-reactive protein have been negative. X-ray studies of the chest, kidneys, and gastrointestinal tract have been normal. An intermediate tuberculin (PPD) test was negative. Hemostatic studies have failed to reveal any defect (Table 1). Repeated urinalyses have yielded normal findings except for persistent hematuria in the range of 25 to 200 cells per high-power field. Urinary concentrating ability and the phenolsulfonphthalein (PSP) tests have been normal, although on one occasion creatinine clearance was 65% of normal, and occasionally there have been low colony counts of coliform organisms. Percutaneous renal biopsy was normal by light and electron microscopy. An audiogram revealed moderate nerve deafness. Ophthalmological examination showed no visual or other abnormalities.

Case 2 (Fig 1). The 16-year-old son of the first patient (Case 1) was seen with middorsal back pain. History included measles, mumps, chicken pox, and asthmatic bronchitis, but there was no history of rheumatic fever, scarlet fever, pyelonephritis or glomerulonephritis. There were no visual or neurological symptoms but an audiogram revealed mild nerve deafness. Physical examination showed only a Grade I systolic apical murmur after exercise.

Urinary findings were normal except for microscopic hematuria of 20 to 100 red cells per high-power field on numerous occasions. The tests for blood glucose, blood urea nitrogen, uric acid, calcium, phosphorous, and alkaline phosphatase gave normal results; the electrolytes, blood counts, and serology were all normal. The intermediate PPD test was negative. Chest x-ray films were reported as normal except for rudimentary cervical ribs. Intravenous pyelography and cystoscopy failed to disclose the cause of the hematuria, and hemostatic studies (Table 1) yielded normal findings. Urea clearance, urine dilution and concentration tests,

Reprint requests to: Richard D. Fritz, M.D., 425 East Wisconsin Avenue, Milwaukee, Wis. 53202.

PSP tests, and urine cultures were normal. Ophthalmological examination was normal. Permission was not granted for a percutaneous renal biopsy. The patient has remained asymptomatic but has persistent microscopic hematuria.

Discussion

This family, together with those reported by others, emphasizes the importance of considering the possibility of hereditary or familial hematuria in all cases of persistent and asymptomatic hematuria without obvious explanation, and of investigating other members of the family before submitting the patient to repeated and often fruitless urological instrumentation. Even though the syndrome is poorly defined and has been reported under many titles (Table 2), it is sufficiently well documented to establish its existence. The salient features are continuing microscopic and occasionally macroscopic hematuria in the patient and in other members of the same family in one or more generations, early renal deaths in affected males, and associated extrarenal manifestations including deafness, ocular abnormalities, and possibly peripheral neuropathy. Infection of the urinary tract, perhaps often iatrogenic, seems to be present in most of the recognized cases and in some instances plays an important role in the clinical course.

TABLE 1—*Coagulation studies*

	Case One	Case Two	Normal Value
Bleeding Time (min)	5½	3½	3– 5
Coagulation Time (min)	7½	8½	8– 12
Prothrombin Time (sec)	15.0 sec. Control 16.0	16.0 sec. Control 16.0	16– 19
Plasma Clotting Time (sec)	79	87	90–150
Partial Thromboplastin (sec)	65	53	60–100
Prothombin Consumption Time (sec)	48	23	over 30 abnormal below 20
Fibrinogen (mg%)	240	291	200–400
Platelet Count (mm³)	320,000	341,000	200,000–400,000
Prothrombin (units/ml)	291	252	200–350
Thromboplastin Plasma	Normal	Normal	
Serum	Normal	Normal	

TABLE 2—*The confusing nomenclature of "hereditary hematuria"*

Hereditary Chronic Nephritis
Hereditary Renal Disease with Deafness
Hereditary Interstitial Pyelonephritis
Hereditary Renal Dysfunction with Associated Nerve Deafness
Hereditary Nephritis, Deafness, and Renal Foam Cells Syndrome
Hereditary Hematuria, Nephropathy and Deafness Syndrome
Congenital Hereditary Hematuria
Hereditary Nephropathy, Deafness, and Renal Foam Cells
Hereditary Interstitial Nephritis Associated with Polyneuropathy
Familial Nephritis
Familial Erythromelalgia and Nephritis
Familial Glomerulonephritis and Amino-Aciduria
Idiopathic Hematuria
Idiopathic or Congenital Hereditary and Family Hematuria
Renal Disease, Inner Ear Deafness, and Ocular Changes

Case 1 illustrates especially well the importance of searching for a familial incidence of hematuria. The initial episode in this patient appeared to be an ordinary hematuria but investigations failed to provide an explanation, and the subsequent course was that of recurrent pyelonephritis. Questioning revealed the existence of known hematuria in other members of the family and ultimately confirmed the presence of a renal problem in 11 of the 28 members who were available for study. Associated extrarenal manifestations were found in the instances indicated (Fig 1). Case 2 illustrates the asymptomatic microscopic hematuria that may be found in members of a family of this sort and emphasizes the ease with which these cases may be missed.

When seen in isolated instances and observed over a short period of time, this syndrome may seem to be benign and of little importance. It is evident, however, in the recorded cases and our own that if these families are followed for extended periods, the syndrome may be found to be of considerable gravity, particularly in the affected males. In Guthrie's original cases essential hematuria was the predominant manifestation but as the family was followed and restudied during more than two decades by other physicians, it became apparent that several of the males died at an early age with uremia due to glomerulo- or pyelonephritis or a combination of both. A similar situation is suggested in the two male deaths in the first generation of our family.

Microscopic renal examination at autopsy in recorded cases has almost universally shown changes of both glomerulonephritis and pyelonephritis together with the frequent presence of foam cells, although Whalen and associates[17] have stated that foam cells are by no means specific for this hereditary nephropathy. These findings are necessarily terminal, however, and have little significance so far as the early bleeding is concerned, the mechanism of which is obscure.

The extrarenal manifestations associated with this genetic abnormality are of interest. In 1927, Alport[4] first reported deafness, and subsequent observations have shown a high incidence of aural involvement even in asymptomatic relatives. The patient with renal disease and a hearing aid should always arouse suspicion. Both of our patients had

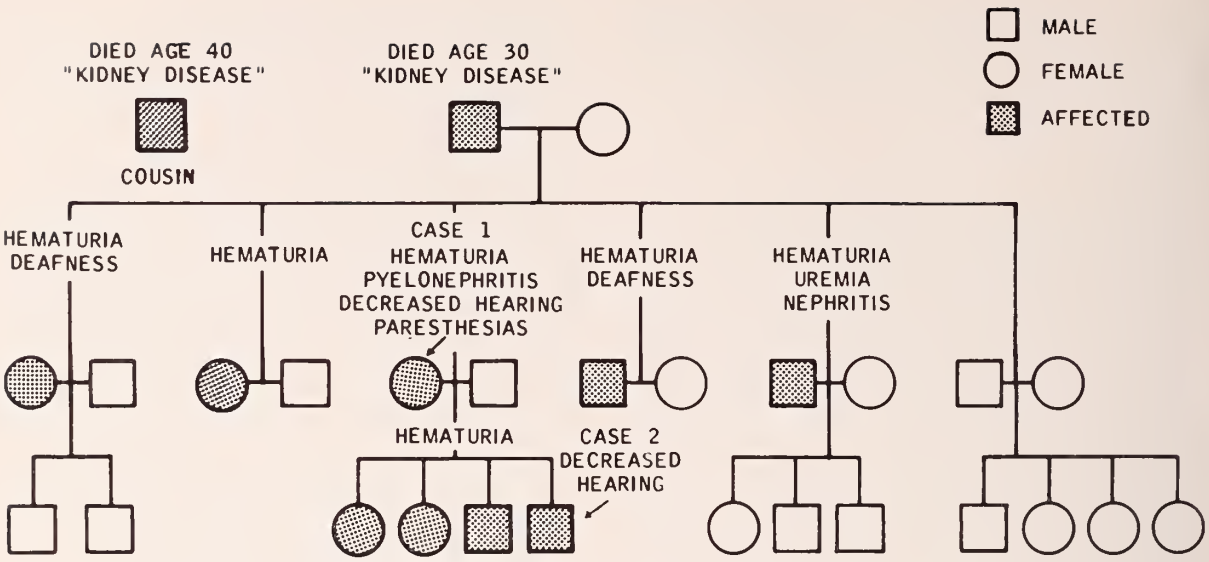

Fig. 1—A study of 28 members in three generations of a family, 11 of whom have been affected by hematuria.

audiograms indicative of moderate nerve deafness. Ocular manifestations have also been reported: lenticonus, abnormal conical projection of the lens; spherophakia; spherical lens; and subcapsular cataracts.[23] There were no visual or other ophthalmologic defects in our patients. Reports of peripheral neuritis with loss of myelin sheaths[24] are not convincing since uremia from any cause may be associated with peripheral neuropathy. Erythromelalgia was noted in some members of the family reported by Cross.[25] Interestingly, our first patient occasionally experienced painful paresthesias of the hands and feet.

The possibility that this syndrome may be a manifestation of, or related to, a hemostatic defect has been carefully considered in our cases and appears to have been eliminated (Table 1).

Summary

A family with persistent unexplained hematuria in 9 of 28 members is reported. Two of the individuals with hematuria have been extensively studied and found to have no hemostatic defects. Two males died at an early age of "kidney disease." The importance of associated extrarenal findings is stressed as a helpful diagnostic aid. Of the many names suggested for this syndrome "hereditary hematuria" would seem to be the most suitable.

ACKNOWLEDGMENT: The authors would like to express their appreciation to Dr. Shirley Johnson for her aid in compiling coagulation data and to Dr. Harry Beckman for valuable assistance in reviewing this paper.

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SPECIAL TO THE JOURNAL

First-Year Results of a Wisconsin Infant Immunization Survey

By H. GRANT SKINNER, M.D., M.P.H. and WILLIAM L. GILBERT, B.Sc., Madison, Wisconsin

IN THIS JOURNAL in December 1966, Dr. Josef Preizler published the results of the first three months of a Wisconsin infant immunization survey. The information from the first full year of the survey is incorporated in this report.

As previously reported, the sample included approximately one-third of all children born in 1965 who reached the age of 18 months. Because Milwaukee and Waukesha have their own excellent programs, they have not been included. During the first year 16,288 questionnaires were mailed. There were 12,334 completed returns tabulated; thus 75% of those contacted responded to the questionnaires.

The table gives the percentages of immunization among infants whose parents responded to the immunization survey by county and cities with a population of 30,000 and over.

COMMENTS

The validity of the sample for the state based on the random choosing of the cases is a firm result (Table 1). However, where the number of letters sent to a county is low in relationship to the average yearly births, a bias is possible. In addition, a low percentage of returns on letters sent introduces a further possibility of bias. Actually, the overall high percentage of returns is unusual.

Poliomyelitis can be considered eradicated in Wisconsin, although re-introduction is possible if there is no herd immunity. In addition, early life immunity is believed to be less hazardous than late immunization for military service, foreign travel, and the like. The foundation concept requires consideration with polio vaccine as do the relatively low levels reported on behalf of infants surveyed in certain areas of the state.

TABLE 1—*Percentages of immunization*

	State Counties*	State Cities** (except Milwaukee and Waukesha)
Measles	53%	67%
Smallpox	57%	70%
Poliomyelitis	62%	69%
D.P.T.	74%	78%

*Counties excluding cities over 30,000 population.
**Cities with a population of 30,000 and over.

Measles is still occurring in the state; therefore, the level of immunity is too low. Although no one has set a level which will eradicate measles, early reports from extremely well immunized areas indicate that re-introduction of the virus results in cases among the unimmunized.

Smallpox has not occurred in Wisconsin for a long time. The controversy about the vaccine continues and low levels of smallpox vaccination are reported.

Neither diphtheria nor tetanus have caused disease in Wisconsin in the group under discussion for some years. Yet, in spite of relatively high levels of pertussis* immunity, this disease continues to produce morbidity and mortality. Two recent outbreaks in Wisconsin were discovered when infants became apneic and were admitted to the hospital.

In both cases, earlier whooping cough was not recognized in older unimmunized siblings. One of these epidemics attacked all susceptible children in three above-average sized families. At least one unbeliever, the father of one family, was converted to vaccine use by the sleep loss he suffered due to the whooping of his children.

* The State Laboratory of Hygiene has a kit available for the isolation and identification of Bordetella pertussis, with the aid of the fluorescent antibody technique.

Additional tables which give further results of the survey by counties and cities and by disease and level of immunization can be furnished upon request to the Wisconsin Division of Health, 1 West Wilson Street, Madison, Wis. 53702.

Therapeutic Dilemmas

No. 10 of a Series

Editor:

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COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

ESTROGENS FROM CRADLE TO GRAVE

Moderator: JOHN O. CHAMBERLAIN, M.D.
Participants: BRIAN E. STAKEM, M.D.
F. JACKSON STODDARD, M.D.
ROBERT R. KOENIG, M.D.
FREDERICK G. GAENSLEN, M.D.
SANFORD R. MALLIN, M.D.

Dr. John O. Chamberlain: In the conference this morning we will deal with the interesting case of a post-menopausal arthritic woman from my own practice, who had been receiving cyclic estrogen therapy (1.25 mg Premarin daily for 21 days of each month) for a year because of evidences of waning estrogen effect and mild osteoporosis, who then presented with symptoms that made hospitalization advisable. The findings in this patient will serve as basis for discussion of the broad subject of estrogen therapy. Doctor Stakem will present the case.

Dr. Brian E. Stakem (Resident in Medicine): The patient was a 63-year-old white woman who was admitted with complaint of constant, dull, low-back pain associated with frequent micturition and a three to four times nocturia. There was no history of vaginal bleeding. Blood pressure was 145/95 mm Hg, pulse 75, temperature 98.2 F. Hemoglobin was 10.8 gm. White blood cell count, 8,047 per cu mm. Microscopic study of the urine revealed 20 to 30 erythrocytes per high-power field. A grapefruit-size pelvic mass was palpated. X-ray study revealed an extrinsic mass compressing the left pelvic ureter and colon, plus diverticulosis. At operation, which was performed for presumptive endometrial carcinoma, the entire uterine cavity was found to be filled with blood and secretions; the uterine tissue mass that was removed weighed 190 gm and measured 12 x 5 x 5 cm. The external cervical os was completely occluded and the endocervical canal tremendously dilated to 9 cm in circumference. There were histological features consistent with subacute cervicitis.

Dr. Chamberlain: Doctor Koenig, will you kindly discuss the cytohormonal aspects of such cases as this?

Dr. Robert R. Koenig (Department of Laboratories): In our routine reports on vaginal smears we try to make rough estimate of the estrogenic effect—we say either that it is sufficient or deficient. But if more elaborate definition is desired, we obtain a maturation index. This is the determination of the relative percentages of three basic cell types in the vaginal mucosa: the parabasal cells, the intermediate cells and the superficial cells. The more estrogen, the more maturation and the greater amount of transformation from the parabasal, through the intermediate, to the superficial cells. This can be reported in the same way as one reports on a hematological specimen: a shift to the right (i.e., in relative percentage of superficial cells) is indicative of estrogen predominance; to the intermediate or mid-zone area, of progesterone predominance; and to the left, the absence of both.

The graph (Fig 1) presents the maturation indices throughout life. The superficial cells are represented by dots, the intermediate cells by continuous lines, and the parabasal cells broken lines. At birth, as you see, there are no parabasals, only 5% superficials and 95% intermediates; this mid-zone reaction is due to hormones circulating in the mother's blood. About two weeks after birth, and throughout childhood, the shift is to the left (note that there are 80% parabasals), and this persists until the menarche. The presence of superficial cells during this premenarche period raises suspicion of a granulosa cell tumor.

During the reproductive period the estrogenic effect is highest at the time of ovulation; there may be 60% to even 90% superficial cells; then just before menstruation a

shift to intermediate cell predominance occurs. It is this shift we look for when we are sent a smear for determination of ovulation: if the shift from the right to the mid-zone has not occurred, the patient is not ovulating. Throughout pregnancy there is a mid-zone type of ratio, and as soon as the baby is born a radical shift to the left. Note that the ratio in pregnancy is almost the same as that at birth, while that at postpartum is comparable to what we call teleatrophy in the menopausal woman.

The menopausal woman can go into two phases: the estratrophy or the teleatrophy. In estratrophy the ratio is midzonal; the cervical epithelium is well protected by many intermediate cells, and women with this type of atrophy do not have senile vaginitis. Some women, however, switch all the way down to teleatrophy, in which there are 100% parabasal cells and complete lack of maturation; these individuals develop senile vaginitis. The smear of a patient of this sort, to repeat, may resemble completely that of a postpartum woman.

A word about taking the smear. The best material you can send us for estrogenic determination is from the vaginal pool, or the specimen may be taken from the lateral walls of the vagina at the level of the tip of the cervix. The collection should be made very gently; do not scrape hard. And remember, please, that inflammation obliterates the normal appearance and prevents accurate estimation of estrogenic effect.

In conclusion, I would say that the cytohormonal evaluation can be definitive and diagnostic and therefore of great assistance to the physician.

Dr. Chamberlain: Thank you, Doctor Koenig. Doctor Stoddard, would you like to present the subject from a gynecologic standpoint?

Dr. F. Jackson Stoddard: In addition to the maturation index, which Doctor Koenig has so well described, there is a simpler office procedure that sometimes suffices. Indeed, pelvic examination alone will often enable you to recognize the atrophic changes indicative of extreme estrogen deficiency. But if it seems desirable to take a specimen, as Doctor Koenig described, smearing the material on a slide, letting it dry, and then inverting it over a well of freshly prepared Lugol's solution, will often provide a serviceable rough evaluation of estrogen activity. A totally brown-looking smear indicates good cornification; a yellow smear, atrophy; and yellowish brown, something in between, or mid-zone.

In the case we are considering this morning, the uterus in situ was a much more impressive structure than the one that was ultimately sent to the laboratory. It was about the size of a football, its walls were markedly thinned out and it was full of blood. I felt at first that we were probably dealing with a hematometra secondary to endometrial carcinoma, because once or twice each year I see an elderly patient with lower abdominal pain accompanied sometimes by fever, almost always without uterine bleeding or purulent vaginal discharge, and a large pelvic mass that ultimately turns out to be endometrial carcinoma and hematometra. What this present patient was ultimately found to have—a stenosed cervix with blood piling up in the uterus in association with estrogen therapy—was formerly a very unusual finding but now we are encountering it more frequently since Robert Wilson, in New York City, and some of his satellite authors, have begun writing in the ladies' magazines about estrogens, aging, the menopause and "that tired feeling." More women are demanding and getting estrogens, and we are seeing more of these cases.

I should like to touch briefly upon the indications and hazards of estrogen therapy in certain specific instances. Years ago, we accepted postmenopausal bleeding as an alarm signal, but nowadays this symptom awakens less apprehension than it should. So many women are now getting exogenous estrogens, and bleeding is recognized as a complication of such therapy. Furthermore, a negative Papanicolaou smear is regarded by many physicians as proof of the absence of cancer, and the patient is allowed to continue on the estrogens with at most a slight alteration in dosage. A year or so ago, in preparation for discussion of the subject in a meeting, I made inquiries among gynecologists and in a couple of days received accounts of 20 patients who had been assured, on the basis of a negative Papanicolaou smear, that they did not have cancer; and then within 9 to 24 months they were subjects of definitive diagnosis and treatment for endometrial carcinoma. I cannot make precise statement of where to stop in diagnostic procedures routinely. Of course we cannot curette every

woman who spots postmenopausally; but it is also certain that if we do not curette some of them it will be regretable.

There are a fair number of single women, and nulliparous married women, who come to the menopause with a marked cervical stenosis, as was the case with our patient this morning. Fortunately, in most instances when such a patient is given estrogens, the cervical canal enlarges and thus a way out is provided for the blood. But in some cases, such as the present one, this enlargement does not take place, and the uterus balloons up with blood. Why our patient developed this unyielding stenosis I do not know. She had borne two children, but I suspect she might have forgotten a cauterization of the cervix at some time in the past. She had been oophorectomized long ago; maybe it was done then.

I think it is advisable to probe the canal before starting estrogen therapy in some of these cases; perhaps not in all, because occasionally the uterus may be perforated if you try to probe too forcefully. If you cannot safely pass the probe, I suggest another trial when the tissues have softened after several months on estrogens. Of course if the woman bleeds and has some withdrawal bleeding, you will know she doesn't have significant cervical stenosis even though you can't conveniently pass a probe. Sometimes on bimanual examination, which should be done several times during the first year of estrogen therapy, you will find that an originally atrophic uterus has become, at 3, 6 or 12 months, the size of that of a woman in the reproductive years. And that will give rise to some worry that there may be withdrawal bleeding building up inside that uterus.

When is postmenopausal bleeding in a woman on estrogens a danger signal? Certainly it is important to take into account the considerable variability in responsiveness of individual patients. I have occasionally seen women bleed when administration of only 0.1 mg of stilbestrol was stopped, whereas other women will get along on 1.0 mg a day and not bleed when this is stopped. Sometimes just a drop in dosage rather than discontinuance will result in bleeding; and there are times when bleeding will occur without reduction or withdrawal, apparently as a result of decrease in endogenous estrogen production or reduction in effectiveness of the hormone. And in some instances an

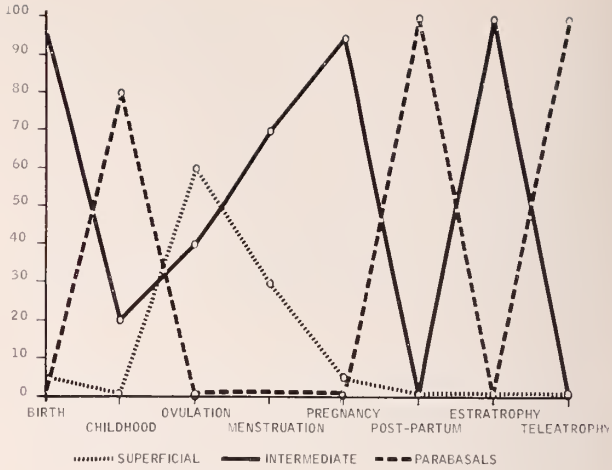

Fig. 1—Maturation indices throughout life.

individual's endogenous estrogen production will lead to intermittent and sporadic bleeding.

So when is the bleeding a danger signal? In a woman whose bleeding occurs relatively soon after stopping the estrogen therapy, many of us now wait a month or six weeks before doing a dilatation and curettage, provided the uterus is not enlarged and the Papanicolaou smear is negative. If the bleeding persists after that time, I schedule for a dilatation and curettage. I do not favor routine endometrial biopsy because it may defeat one's diagnostic purpose; the experience may be a very uncomfortable and traumatic one for the patient and cause her to postpone further examination until months or years later, when she straggles into someone else's office with a full-blown endometrial carcinoma. If we are really anxious to sample the endometrium we had better bring the patient in for a thorough dilatation and curettage to be sure of what we are dealing with. Of course in a woman with a patulous cervical canal we can fairly often diagnose endometrial carcinoma with a curette in the office.

One of the reasons why we did not diagnose hematometra preoperatively in our present patient was that neither Doctor Chamberlain nor I could see or feel the cervix with certainty. I could tell that a dilatation and curettage would be impossible. We both thought it likely that we were dealing with a big ovarian cyst, since she had had another one removed previously.

I feel that the maturation index is of limited value, because we know that certain women with a well-cornified vaginal smear

have miserable vasomotor symptoms and are relieved by estrogens, while others have an atrophic smear and no symptoms at all. Furthermore, I think that little shades of difference in estrogen activity during the reproductive years, as revealed by the maturation index, or the "femininity index" as Wilson likes to call it, are not reflected by fluctuations in "that tired feeling" that are correctable by alterations in estrogen dosage. The index simply is not that reactive, and furthermore you will find different indices at the 5th, 12th, and 18th days of the menstrual cycle. And the presence of infection, as Doctor Koenig has pointed out, will invalidate the index, as will irritation also. Actually the therapeutic test is a more satisfactory measure of the patient's need for estrogens.

Should every postmenopausal woman receive estrogens? Considerable evidence is accumulating that a fair number of them still have some degree of estrogen activity; Doctor Koenig mentioned that intermediate cells may be seen in the vaginal smear way up into old age. We have seen patients who had the first hot flush of their lives after having their ovaries removed in the 70-year age bracket; undoubtedly they had been having some slight endogenous estrogen activity all along after the menopause. It is highly likely that adrenal androgens can be converted into estrogens by the liver; ACTH administration to a castrated individual can definitely increase estrogen activity. All of us remember the period when thyroid substance was prescribed for menstrual ailments; when it was stopped we really had a hypothyroid case on our hands even though the patient may not have been hypothyroid before we began the treatment. Similarly, if we place a postmenopausal patient who has had a few flushes on estrogens, and then try to withdraw them after a while, we can provoke some really uncomfortable vasomotor symptoms. I have seen severe hot flushes of this iatrogenic type produced also in women with gonadal dysgenesis (Turner's syndrome) who have been taken off estrogens after having been on this therapy for a while in the attempt to develop secondary sexual characteristics.

I think that the ideal woman to treat with estrogens should have the following characteristics: (a) recent hysterectomy and oophorectomy; (b) small, soft breasts to facilitate palpation; (c) low-back pain; (d) a family history of atherosclerosis and hypertension; (e) atrophic vaginitis, dyspareunia and hot flushes; and (f) no family history of breast or endometrial carcinoma. So far as engendering or promoting cancer with estrogen is concerned, I feel the evidence is so unconvincing that if we employ intermittent administration we are adequately protected.

Dr. Chamberlain: Thank you, Doctor Stoddard. Doctor Mallin, would you like to make any remarks relative to estrogens and arteriosclerosis?

Dr. Sanford R. Mallin: This area is of interest primarily because of clinical observations that have accumulated through the years. First, and most widely known and accepted of these observations, is the relative freedom of the menstruating female from arteriosclerotic heart disease. Second, that the incidence of arteriosclerotic manifestations, particularly myocardial infarction, rises markedly after the menopause. Third, that the individual who is oophorectomized at any age seems to show a male-like incidence of arteriosclerosis. Fourth and finally, that Katz and co-workers in Chicago were able to show that estrogen administration is sometimes able to prevent and even reverse experimental arteriosclerotic lesions induced in chickens by high cholesterol diet. Estrogen appears to lower serum cholesterol through an effect on the low-density beta lipoproteins. Katz sought to make direct therapeutic application of these facts by administering estrogens to male patients suffering their first myocardial infarction. The results, however, were equivocal and disappointing, and there was poor patient acceptance. In the small group of individuals who continued the therapy for a long period of time there was a reduction in the incidence of recurrent infarction.

At this time I should say that there is no clear-cut indication for administration of estrogens to males except of course in palliation of prostatic carcinoma. And I am not willing to say that all postmenopausal women should be given estrogens to prevent arteriosclerosis, since substantial evidence in support of such therapy is lacking, although when the hormone is being given for another reason, it is convenient to think that possibly we are diminishing arteriosclerotic changes as well. But we do not know that the dosage

of estrogen preventive of hot flushes is adequate to influence either vascular or bone changes.

I fully agree with Doctor Stoddard that "femininity forever" is not a program to be recommended for general support.

Dr. Chamberlain: Thank you, Doctor Mallin. Doctor Gaenslen, what would you say of the estrogens in osteoporosis?

Dr. Frederick G. Gaenslen: As our population grows older we are of course seeing more individuals with extensive demineralization of the skeleton: the person with intractable back pain of long standing, or one who has a compression fracture incident to a minor physical effort. A really tremendous amount of time and effort has been devoted to study of bone metabolism, but we are still armed only with empirical observations regarding cyclical administration of estrogens for palliative purposes. We have followed many osteoporotic patients, some practically bed-ridden at the beginning of therapy, who on minimal dosage of estrogen have resumed activity and become able to travel and lead normal lives—only to break out of control and become symptomatic again. And there are some patients, too, who can avoid breast engorgement and bleeding only through holding dosage down to low normal levels for many years, who then subsequently become tolerant of, and require, much higher dosage. I think these changes are due merely to decreases in the intrinsic hormonal levels as age advances. Recently there is talk of the effect of fluorides in augmenting the action of estrogens in osteoporosis through helping to bind calcium into the skeleton. But obviously osteoporosis is a complicated problem, a malady of many causes—disuse, menopause, dietary deficiencies, iatrogenic in the case of excessive corticosteroid use—all of these things, and undoubtedly many more, enter into the picture.

I have no hard and fast program for management with estrogens, but in my experience a cycle of four days on the therapy and three days off has probably succeeded a little better than three weeks on and one week off. As for dosage, most frequently I use 0.625 mg of Premarin and 5 mg of methyltestosterone.

Dr. Chamberlain: (summarizing): This morning we have had under consideration a patient who was found at operation to have a stenosed cervix with hematometra associated with use of estrogens for menopausal symptoms. The findings provoked discussions of estrogen therapy from the laboratory, gynecologic, vascular, and orthopedic standpoints.

A STUDY OF DISPOSABLE SURGICAL MASKS

PAUL O. MADSEN, MD and RENATE E. MADSEN, MD, Madison, Wis.: *Amer. Jrl. Surg.* 114:431–435 (Sep) 1967

A combined in vivo and in vitro testing method for surgical masks is presented. The mask to be tested was placed covering the nose and mouth of a manikin which was accurately constructed according to human measurements. The manikin was then placed in a special counting chamber and a known number of bacteria were blown through the mask by a nebulizer and an automatic respirator closely resembling a human sneeze or cough. The chamber was then evacuated completely through an Anderson sampler so that all bacteria in the chamber which had not been retained by the mask would be collected and counted within this sampler.

The efficiency of the different masks was expressed as the percentage of bacteria retained by the masks as compared to a control when the manikin did not wear a mask. The set-up closely resembled that of a surgeon bent over a patient in the operating room when he is coughing or sneezing wearing a mask covering his nose and mouth.

The efficiency of the different mask material was found to be in this order: Polypropylene fibers (Filtron), polyester-rayon fibers (Aseptex), glass fibers (Deseret) and cellulose (Paper).

MORPHOLOGICAL INVESTIGATION OF HUMAN BREAST CANCER

J. A. SYKES, (Research Dept., Southern California Cancer Center, Los Angeles), L. RECHER, P. H. JERNSTROM: *J. Nat. Cancer Inst.* 40:195–223 (Feb) 1968.

Twenty-two human breast cancers and two benign breast tumors were studied in the electron microscope. Human breast tumors were found to retain certain characteristics of their tissue of origin. There was some ductal differentiation in all these tumors. Unlike normal epithelial cells of the mammary gland, tumor cells frequently showed intracytoplasmic ductules and numerous cytoplasmic microfibrils identified as tonofibrils. These two cytological features were considered pathognomonic for cancer cells. The significance and nature of the nuclear "inclusions" and of some cytoplasmic structures described are unknown. No structures resembling any known infectious or oncogenic viruses were observed in the human breast material examined.

From the Veterans Administration Hospital and Departments of Surgery and Anesthesiology, University of Wisconsin Medical School.

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Morquette School of Medicine, Milwoukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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Management of Acne Vulgaris

By DEREK J. CRIPPS, M.D., Madison, Wisconsin

■ ACNE VULGARIS is an obstructive process of the sebaceous follicle caused by comedones, which may be followed by an associated subacute or chronic inflammation, presenting as pustules or cysts. There appears to be a genetic predisposition for acne which is commonly seen in the young, usually at puberty, and may extend into early adult life. The sites most commonly involved are the face and upper dorsa of the trunk and chest. Treatment of acne is of course not only important from the cosmetic aspect and reducing eventual scar formation, but from the social and psychological implication on the youngster's formative years. The management of acne, which includes both topical and systemic therapy, will be described under the basic clinical stages, although these may occur at the same time.

Oily Skin and Comedones

Removal of comedones, and soaps: Clinically, acne may first present as an oily skin with comedones or blackheads, which is a mass of keratin and sebum blocking the dilated follicular orifice. At this stage comedones should be removed with a comedone extractor, and visits to the physician may be required every two weeks until under control. Washing the face twice a day with soap and a flannel is a good start, but there are some excellent soaps available, such as Brasivol, which contains synthetic particles of aluminum oxide and hexachlorophene; or Pernox, which contains polyethylene particles, as well as sulfur 2%, salicylic acid 1.5%, and hexachlorophene 1%.

Doctor Cripps is Associate Professor of Dermatology, University of Wisconsin Medical Center.

Drying agents: After washing twice a day, a drying agent can be applied and rubbed in well. There are many commercial brands available, but it is best to become familiar with a few of these preparations and know the strengths of the therapeutic agents, most of which contain resorcin (R), salicyclic acid (Sa) and sulfur (Sf) in various strengths and combinations, some of which will be listed:

- Acnomel (Sf 8% and R 2%)
- Resulin (Sf 8% and R 2%)
- Acne-Dome cream (Sf 8% and R 6%)
- Rezamid (Sf 5% and R 2%)
- Fostex cream (Sf 2% and Sa 2%)
- Komed (Sa 2%, R 2%, and sodium thiosulfate 8%)
- Cort-Acne (Sf 5% and R 2%)
- Fosteril (Sf 2%)

Cosmetic preparations are usually important to the girls and women, and can be obtained in various blonde or brunette shades, such as found in Acnomel, Resulin, Acne–Done Cream, and Fosteril. For boys or men, the author usually prescribes S.A.R. lotion, which may contain your prescribed strengths of salicylic acid (0.5 to 2%) and resorcin (1–6%) in 70% isopropyl alcohol; this can be suggested under the guise of an after-shave lotion, and followed with a night time application of lotio alba, a useful addition to the program.

The purpose of the drying agents is to remove the shiny appearance of the oil and cause peeling or scaling, which should be just visible but not too uncomfortable for the patient. Overdrying can easily be corrected by reducing the number of applications or

selecting a weaker or half-strength preparation.

Peeling paste: For the resistant or occasionally lax patient, a peeling paste can be applied for one to five minutes by the physician in the office. Such a paste can be made up as follows in grams to a total of 487 gm: resorcin, 224 gm; zinc oxide, 56 gm; kaolin, 28 gm; peanut oil, 67 gm; and anhydrous wool fat, 56 gm, in petrolatum, 56 gm.

Dandruff is often associated with acne, and if the oily hair is worn across the forehead, acne is harder to control in this area. Shampooing with Sebulex or Capsebon twice weekly, or Selsun less frequently, is helpful.

Ultraviolet light: Acne tends to improve in the summer, and worsen in the fall and winter. Sunbathing should be encouraged, and in some instances artificial ultraviolet light (UV) light source may be used, such as a cold or hot quartz mercury lamp, gradually increasing the minimal erythema dose. There are a number of commercially available lamps such as Hanovia, and the smaller ones do as well, but a longer exposure time is required. It is advisable to remind the patient that halving the distance of the lamp to the skin will increase the light intensity by four times. The effect of ultraviolet light is somewhat similar to the drying agents.

X-ray: This should be left to the expert, and reserved for the severe cases of cystic acne, to decrease the size and activity of the affected sebaceous glands. As a rule, a maximum total of 800 R in ten divided doses at two to three week intervals can be used.

Cystic Acne

Failure to relieve obstructed sebaceous glands may be associated with an overgrowth of mainly Staphylococcus albus and Corynebarterium acnes. These bacteria apparently act on the triglycerides in sebum to form free fatty acids, and this is partly responsible for inflammation in the surrounding dermis.

Antibiotics: Reduction of inflammation and free fatty acid formation can usually be achieved by small amounts of antibiotics such as tetracycline, 250 mg daily or even 125 mg daily for a few weeks, and, depending on the success of therapy, repeated at intervals or continued for several years. Demethylchlortetracycline (Declomycin), 150 mg a day, is also useful but can cause photosensitivity, although less likely in these doses.

Incision and injection: Release of cystic contents with the point of a fine blade or injection of triamcinolone acetonide suspension, 10 mg/ml diluted 2 to 4 parts with sterile physiologic saline will cause considerable involution of persistent lesions.

Wet packs: Vlem–Dome or Vleminckx's solution (NF), one teaspoonful to a pint of hot water, can be applied as a wet pack for 10 to 30 minutes once daily for a few days. The disagreeable smell of released sulfurated hydrogen warrants a well ventilated room, or the back porch. Much the same effect for milder cases can be achieved with a nightly application of Sulpho-lac cream (modified Vleminckx's 57%).

Estrogens: Whereas testosterone causes increased sebum and exacerbation of acne, estrogens cause suppression. A number of patients receiving progestin-estrogen cyclic therapy for contraception have had improvement, and in some instances even more so after doubling the amount, for example to 5 mg norethynodrel and 0.15 mg of mestranol. This form of therapy, however, still requires further careful evaluation, and is probably best reserved for the young married woman in which clinical trial for three to four months showed worthwhile results.

Dermabrasion: Removal of scars by abrasion with a rotating diamond, wire brush, or sandpaper; or topical application of trichloracetic acid is now being viewed with less favor and should be left to the expert. The effect of tincture of time (5 to 10 years) is probably worth one dermabrasion; keloids and postinflammatory pigmentation may complicate the cosmetic result.

General Management and Summary

The importance of diet is debatable, however an increase in weight should be avoided, and if the patient gives a history of exacerbation after eating chocolate, nuts, or Coca-Cola, then these should be avoided. In general, minor acne surgery, with removal of comedones, occasional injection or incision of cysts, tetracycline 250 mg daily, twice daily applications of an abrasive soap such as Brasivol or Pernox, followed by one of the drying agents, will be a helpful and usually rewarding program.

WISCONSIN MEDICAL JOURNAL
VOL. 67, NO. 8 AUGUST 1968

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Comprehensive Planning—Miracle or Menace? A Report on Plans and Action in Wisconsin

Since Nov. 3, 1966, when President Johnson signed Public Law 89–749, a kind of storm has moved around the "Partnership for Health" act.

Some say that Comprehensive Health Planning is a great white miracle . . . a kind of touchstone that will open a new era of utopian health and happiness.

Others say CHP is a dark menace . . . a threat to liberty, the keystone to bureaucratic federal control of health care.

Comprehensive Health Planning is probably neither miracle nor menace. Yet it has the potentiality for both . . . or either.

What's the fuss all about?

It began when Congress, in passing PL 89-749, declared that "fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person. . . ."

Nothing new about that you say . . . health professionals have always believed and acted on that premise. But this is the first time that federal government has declared it a target on so broad a scale.

Congress went on to say: the "attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations. . . ."

Here's a new angle. Not a word indicating that the responsibility rests with "health" or "medical" agencies or individuals. On the contrary, Congress declared that health is everybody's business. The "now" word is "consumer."

Health is a $45 billion business in America this year. Congress has felt the rising heat of a populace more and more interested in how this business is run and with what results.

Congress then declared "that Federal financial assistance must be directed to support the marshaling of all health resources—national, state, and local—to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts."

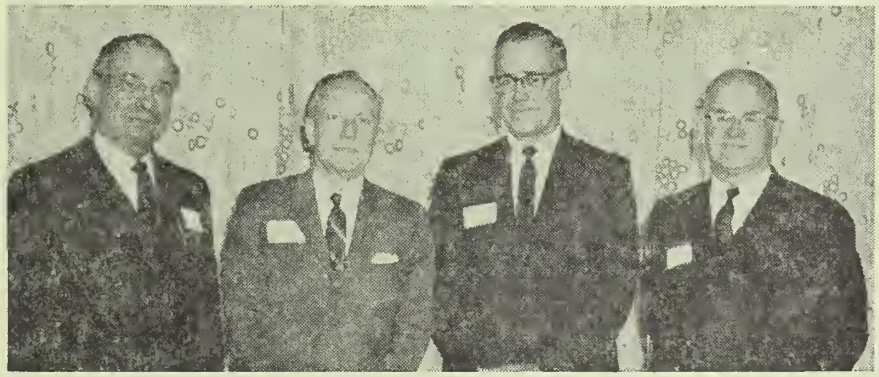
This, too, is a new angle . . . possibly as much as $250,000,000 worth of planning over the next two years alone.

Students of the CHP law are quick to note that, in promotion, little if any mention is being made of the phrase, "but without interference."

Surgeon General William H. Stewart, MD, USPHS, has put it as bluntly as any:

"We do not view the mandate for comprehensive health planning as a new game of musical chairs for the same old players around the same old

(Continued on page 390)



OFFICERS AND ADMINISTRATORS of the Wisconsin Advisory Comprehensive Health Planning Council are, left to right: James W. Wilkie, MD, vice-chairman; T. A. Duckworth, chairman; George H. Handy, MD, council secretary and director of the Bureau of Comprehensive Health Planning; and Vincent F. Otis, deputy Bureau director.

Dr. Handy Explains Ideas on Health Planning Law for State

George H. Handy, MD, director of the State Bureau of Comprehensive Health Planning, expressed his philosophy of the planning law at the July meeting of the State Advisory Council in Madison.

"Comprehensive Health Planning offers an opportunity that is unique in the history of government-health provision relationships, namely the planning for solution of problems based on local identification of needs with professional guidance and consumer advice from interested, concerned persons," Doctor Handy declared.

"In contrast to previous efforts," he said, "Public Law 89-749 as amended is not limited in time or to a collection of programs, or to a certain segment of the health system.

George H. Handy, MD

"This partnership for health program," explained Doctor Handy, "is intended to focus the national health effort on the individual and his family in their community.

"The needs in that community are to be determined by local or areawide groups of professionals and consumers, and transmitted to the state health planning agency, which, with the advice of the Advisory Comprehensive Health Planning Council, is to establish a 'state program' of priorities and goals for the provision of health services by operating governmental and voluntary agencies and groups concerned with health throughout the state.

"This state health planning agency shall serve as a *pivot* for health planning by providing staff for mechanisms of communication for governmental and voluntary agencies and individuals," Doctor Handy stated.

"A major priority will be to endeavor to evaluate programs in terms of the effects on individuals and a change in their attitudes towards acceptance of services," he continued.

"Further, the health services provided will be related to the environmental, physical, mental and social needs within the health resources of manpower and facilities," Doctor Handy declared.

Council members were reminded by Doctor Handy that it is to function "as a nerve extension of the health planning agency, be responsible to areawide needs, consider suggestions for alternative solutions, provide public support, and advise operating agencies for implementation."

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others.

Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1968 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thayer, Director of Socio-Economic Medicine.

COHEN CALLS MEETING ON HEALTH CARE COSTS

Wisconsin will have 15 to 30 representatives at a Regional Conference on Health Care Costs to be held in Cleveland, October 17–18.

Wilbur Cohen, Secretary of the Department of Health, Education, and Welfare, initiated the conference, one of a series following the national conference last year on the same subject.

Four major topics are to be discussed:

1. How to achieve the most effective and efficient use of all the hospitals in a region.
2. How to extend the arm and skill of the physician and what new types of health manpower offer promise in reducing professional manpower shortages.
3. How the private and public health insurance carriers can help to achieve greater cost effectiveness in health services through coverage design, incentive reimbursement, and encouragement of experimentation in the organization of services.
4. How people in the region can work together, utilizing federal and private resources, to chart new directions in the delivery of health services.

Wide representation of public and professional persons is sought, but reports indicate that attendance will be only by "nontransferrable invitation" from the HEW. The State Medical Society of Wisconsin expects to be represented.

COMPREHENSIVE PLANNING

(Continued from page 389)

conference tables. We view it as an opportunity and a challenge to move health affairs up where they belong—in the main arena of political and social decision-making."

Comprehensive Health Planning . . . a miracle? Hardly. But it does hold great promise for better health for more people IF there is truly enlightened participation of the body politic in difficult problems of health manpower, health facilities, and health services.

Comprehensive Health Planning . . . a menace? Possibly. There are many in the private sector who point to the dismal record of health care when it has been rooted in political action. They believe there is substantial wisdom to the old saying: "Keep Politics out of Medicine."

And Surgeon General Stewart's assertion that health affairs should move into the main arena of political and social decision-making are unnerving words, indeed.

And that's what the fuss is all about.

Set Guides for Local Planning Agencies

Must there be an Areawide Health Planning Agency in each area of Wisconsin?

How does an Areawide Planning Agency get started?

What are the rules under which such an agency must operate if it is to get federal grants-in-aid?

These are questions being asked in many quarters, by health and "non-health" people alike.

The director of Comprehensive Health Planning in Wisconsin, Dr. George H. Handy says, "our agency is empowered to establish the geographic boundaries of each areawide health planning agency, but we prefer that this be done on a voluntary basis, arising out of the needs and desires of each area."

At present, there is no deadline by which areawide planning agencies must be set up. However, Doctor Handy indicates that areas of the state not voluntarily entering some local planning group would either deal directly with the state agency or be assigned to some areawide agency when seeking funds for health projects.

Doctor Handy makes it clear that his Bureau is charged with promoting the organization of areawide planning agencies and he and his staff are doing just that.

Since creation of the Bureau in June 1966, he or his staff have talked at dozens of meetings in nearly every corner of the state. They explain, urge, and, at times, prod.

They tell doctors the CHP can mean better care for their patients and an easier job for them with more manpower and better facilities, including the suggestion that they get "hep" to computers because they are rapidly coming into use in health care.

They tell consumers that CHP can mean more doctors, more nurses, more and better service facilities, possibly at more reasonable cost . . . but only if they join in a genuine cooperative effort.

They tell hospitals they must coordinate, set up computer centers, combine service facilities such as laundry, emergency rooms or obstetrical beds, and get ready to become the health centers for their areas.

The idea is to create a nucleus of interested persons who will provide leadership to set up a health planning agency to serve their geographic area. It might be one county. More likely it will be several, perhaps even 9 or 10 counties. It may even cross state boundaries.

Such a group, informal though it may be, may make application for a two-year nonrenewable planning grant. The federal grant will put up 50% of the funds to get a full-scale planning agency under way.

To get such a grant, the State Bureau and the USPHS want assurance that the proposed areawide health planning agency will:

1. Be legally incorporated as a permanent nonprofit agency.
2. Serve a clearly defined region of the state. This area should be large enough to provide a basis for developing the full range of health facilities, services, and manpower necessary to assure comprehensive health services, with the exception of highly specialized resources.
3. Be recognized by the major governmental units and public and voluntary health agencies in the area as having responsibility for organizing or conducting a comprehensive health planning program for that area.
4. Create a Board of Directors or an Advisory Council, a majority of whose members must be consumers of health services broadly reflecting geographic, socio-economic, and ethnic groups in the area.
5. Members should include the major public and voluntary agencies, organizations and institutions concerned with physical, mental, and environmental health. This may be done through committees as well as by direct representation by a Board or Advisory Council.
6. Establish a full-time position for a health planning director.

A grant made for the purpose of organizing a health planning program in any area will ordinarily be limited to two years. Operational grants for such planning groups may come later and may be approved for five years on a renewable basis.

URGE MD ACTION*

"Because of its comprehensive scope, Public Law 89–749 makes urgent the necessity of physician participation in health planning. The legislation provides that planning will be concerned with the entire population of circumscribed regional as well as statewide areas. Such planning will include: all health services, facilities, and manpower; and the related environmental, economic, social, and others factors that affect the health of the population. Decisions may significantly affect the organization and delivery of medical care, including the service programs and physical facilities of the individual hospitals and related medical facilities that physicians utilize.

". . . the planning, organization, and distribution of health facilities and services are prime responsibility of organized medicine—responsibilities that should be given a higher priority among the various activities of medical societies at the state and local level."

* "Comprehensive Planning of Health Facilities and Services," JAMA, May 27, 1968, Vol. 204, pp. 808–810.

WPS Enrolls at U.W.

WPS–Blue Shield this month enrolled 15–18,000 U.W.–Madison campus students under its Special Service plus major medical programs. WPS also covers students at 12 other Wisconsin colleges. Over 500,000 persons now have WPS protection.

11 Areawide Agencies Seen for Wisconsin

Wisconsin's "tooling up" period for comprehensive planning is hardly out of the talking stages even though almost two years have passed since Congress enacted the law.

Deputy CHP Director Vincent Otis reports there are only three or four areawide planning agencies in Wisconsin, "but not any of these would meet the criteria established by the new federal regulations without substantial amendments and revisions to their charters and organizational structure."

Vincent Otis

Two of these have now taken steps to get into the act.

MILWAUKEE—The Hospital Area Planning Committee, Inc. (involving Milwaukee, Washington, Ozaukee, and Waukesha counties) is seeking to transform itself into an areawide comprehensive health planning agency to serve "metropolitan Milwaukee and its environs."

The State CHP Bureau and the USPHS have approved a grant of $62,060 for a two-year effort to organize such a planning body.

MADISON—The Health Planning Council, Inc. (now involving only Dane County) is seeking to become the planning agency for a wider area, possibly nine counties. To this end it has sought and received approval for a $30,380 grant from USPHS.

There is activity in others areas, too:

FOX RIVER VALLEY—The Fox Valley Academy of Medicine recently served as host to a meeting of physicians and others interested in comprehensive health planning for Outagamie, Calumet, Winnebago, and Waupaca counties.

State CHP Director Dr. George H. Handy was reported by the *Appleton Post–Crescent* (June 13, 1968) to have told the audience that "at present, there is no method in the Fox River Valley of supplying a total health program for all in the community."

The newspaper reported that interested persons in the area were urged by Doctor Handy to form a committee, set priorities, raise $60,000 (half matched by the federal government), make application for a two-year planning grant, and hire a full-time planner at an annual salary of up to $22,000.

Dr. John Mielke, Appleton, vice-president of the Academy, was reported as indicating "the majority (of physicians in the entire Fox Cities area) would be in favor of the coordinated comprehensive program."

Still another volunteer effort is underway with a different group of interested citizens to create a Fox River Valley planning authority.

CENTRAL WISCONSIN—At least two public meetings have been held in Wisconsin Rapids with a view to stimulating organization of health planning in an area composed of Portage, Wood, Clark, Taylor, Adams, Juneau, and Waushara counties. To date, no specific action has resulted.

At the same time, however, other federally funded projects of a related nature have been started, neither with prior endorsement of the State CHP Bureau. The Office of Economic Opportunity (OEO) has allotted $158,000 to the Wisconsin State University–Stevens Point for a five-county (Wood, Marathon, Portage, Clark, and Taylor) house-to-house survey to determine public attitudes about health care.

A simultaneous "professional" survey of physicians, hospitals, and other health agencies has been funded with about $35,000 by HEW for almost the same area. It will likewise be directed by WSU–Stevens Point, which at this point, reports that "very little is known about how it will be done or just what is involved."

BROWN COUNTY—Interested groups and individuals from Green Bay and the surrounding area are talking about setting up a health planning agency to serve Northeastern Wisconsin.

WAUSAU—The mental health planning group from this area is interested in providing the leadership for creating a broad-scale health planning agency to serve Marathon County and an area north and east.

EAU CLAIRE—The Eau Claire city-county Board of Health, as well as others, have started discussions to develop an area for Northwest Wisconsin.

LA CROSSE—An agency known as the Western Planning Group, Inc. has started talks aimed at creating a health planning agency serving the area between Eau Claire and the Wisconsin River.

FOND DU LAC—Preliminary discussions are underway with a view to merging the health interests of Fond du Lac, Sheboygan, and Dodge counties in a single planning agency.

SOUTHEAST WISCONSIN—Racine, Walworth, and Kenosha counties are considered as a possible planning area.

SUPERIOR/ASHLAND — The four-county area involving Douglas, Bayfield, Iron, and Ashland counties are considered the nucleus of a health planning area for the far Northwest.

Local planning areas must be recognized by the State Bureau for Comprehensive Health Planning. Each proposal for areawide agency is also submitted to the Governor who has 30 days to comment on the "appropriateness" of the areas' plans.

OEO Funds Health Plan

A health care project to serve an estimated 7,000 low-income persons in Adams, Sauk, Columbia, and Juneau counties has been approved by the Office of Economic Opportunity (OEO).

OEO has made a grant of $125,000 to the Central Wisconsin Community Action Council, Inc. which will carry out the project under direction of John Shumway, Wisconsin Dells.

Federal Grants Key to Health "Partnership"

The Federal government, as a result of the Comprehensive Health Planning law, has assumed a new role in health care.

The heart of this program is a series of financial grants aimed at expanding state and local activity in the health field on a broad scale.

Grants are available, under present legislation from now to 1970 for:

1. Statewide plans for Comprehensive Health Planning—(Section A grants)—up to $15 million, of which Wisconsin has received $166,800 for 1967–68 and expects another $165,000 for 1969.

2. Areawide Comprehensive Health Planning—(Section B grants)—up to $15 million which is available on a 50-50 matching basis. So far, Wisconsin has received two grants, one of $62,060 to the Hospital Area Planning Committee in Milwaukee and the other for $30,380 to the Health Planning Council, Madison.

3. Project grants primarily to train "planners"—(Section C grants)—up to $7.5 million is authorized, but grants will be made almost exclusively to schools of public health. Wisconsin has no such schools.

4. Grants for comprehensive public services—(Section D grants)—up to $1 million is authorized. These grants replace all the former "categorical grants" of federal funds received by the old State Board of Health. Wisconsin's grant for 1968 was $1,250,000 which must be used in public health and mental health and 70% of which must go for the provision of health services in local communities. This section is a critical one because it is, in effect the "string" to which all health planning in Wisconsin is attached.

5. Project grants for health services development—(Section E grants)—up to $1 million is authorized. Wisconsin has not yet made any requests in this category. These grants are to provide services to meet health needs in some limited geographic area or of some special signficance, and to develop new programs, ideas, and methods for providing health services. Local health agencies or area planning groups may apply for such grants. They will compete for money on a national basis and grants may be authorized by the USPHS by passing the State Planning Bureau. The federal government regards this area of grants as providing "seed money" for specific innovation projects which will after two years be on their own for support.

In creating the "Partnership for Health," the Congress revamped previous methods of providing categorical grants for a dozen or more health programs operated through state health departments.

*Surgeon General Comments**

"There is no how-to-do-it manual for comprehensive health planning—either prepared or capable of preparation. There is no recipe to follow, no magic button to push. P.L. 89–749 is a genuine expression of faith in a process of planning to meet different priority needs in different ways. It is an invitation to initiative from states and communities. To offer this invitation and then prescribe a formula which must be followed would be to deny the entire purpose.

"As for the role of government in the process, it is the servant and not the master . . . the operating decisions are made by those who are charged with doing the work. Government can synthesize and catalyze; it cannot dictate.

"The accent is on process. The process requires dynamic partnership."

* William H. Stewart, M.D., Surgeon General, USPHS, at National Health Forum, Chicago, Ill., Mar. 21, 1967.

Hailed by some as giving state health boards more flexibility in the use of their federal support funds, others are quick to point out that PL 89-749 now requires the states to organize statewide and areawide comprehensive planning councils in order to get any funds at all.

Thus, the Congress made sure of "voluntary" compliance in planning.

Areawide health planning agencies study problems within their areas and recommend which problems be attacked first. In so doing, they recommend to the state planning agency where federal grant funds should be allocated within the area.

In the same way, the state planning agency (Bureau for Comprehensive Health Planning) determines health care priorities in the state, and recommends which areas get how much in the way of federal grant funds, all subject to approval of the Public Health Service.

Need Information on Comp Planning?

Physicians interested in areawide comprehensive health planning are urged to contact the State Medical Society, Box 1109, Madison 53701, for such publications as:

"Areawide Health Facility Planning–Suggested Guides for Physician Participation."

"AMA Position on Comprehensive Planning"

"The Physician's Role in Areawide Planning"

"The Wisconsin Program for Comprehensive State Health Planning—July 1, 1968—June 30, 1969."

"The Importance of Local Comprehensive Planning for Health."

Speakers and consultants are also available from the State Medical Society so that county societies may have assistance in developing their role in local planning.

WISCONSIN ADVISORY COMPREHENSIVE HEALTH PLANNING COUNCIL, left to right: top row—Richard Jensen, E. R. Krumbiegel, MD, John S. Hirschboeck, MD, Stanley L. Inhorn, MD, John Bacharach, Kenneth E. Beighley, Robert S. Stevenson, Warren Von Ehren, and Lowell Frautschi; middle row—Judge A. L. Twesme, L. J. Ganser, MD, William A. Jahn, George F. MacKenzie, Mrs. R. B. Horschak, L. J. English, DDS, Peter L. Eichman, MD, Adrian Towne, Kirby Hendee, Mrs. Konrad Testwuide, T. A. Duckworth, Mrs. Janet L. Coye, James M. Wilkie, MD, E. H. Jorris, MD, Msgr. Norbert P. Dall, Vincent F. Otis, and George H. Handy, MD; front row—Harris Mahan, Paul B. Mason, MD, John W. Melcher, Grant Larned, Mrs. D. R. Morrissey, Miss Valencia Prock, Mrs. Lloyd Gullickson, and Mrs. James D. Swan; absent—Wesley J. Mooney, George F. Kress, Mark H. Hoskins, Freeman Holmer, and Ronald Stevens.

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CENTRAL WIS. PROJECT TO RECRUIT MDs

A $13,000 campaign to obtain physicians and nurses "to fill the tremendous shortage" in the rural areas of Adams, Columbia, Juneau, and Sauk counties is being proposed to the Office of Economic Opportunity (OEO) by the Central Wisconsin Community Action Council, Wisconsin Dells.

The four counties now have a total of 67 MDs and 313 nurses serving a population of nearly 100,000 and an area of 30,000 square miles.

*AMA Position on CHP**

With regard to comprehensive health planning, it is the position of the AMA that:

"The AMA and the constituent and component societies give unstinted, diligent attention to the process of comprehensive health planning which, at present, places priority on local initiative and decision-making, and that

"The AMA at all levels endeavor to assure through all appropriate means, a system of checks and balances so that state and area planning agencies are not given authority to subordinate local planning efforts and dictate local decisions on health planning."

* Report of Council on Medical Service, AMA, adopted by AMA House of Delegates, June 1968.

New State Bureau Created to Administer Wisconsin CHP Law

Wisconsin moved to implement the "Partnership for Health" on July 20, 1967, when Governor Warren P. Knowles designated the Department of Health and Social Services as the sole state agency for the administration of the state's health planning functions under Public Law 89–749.

Mr. Wilbur J. Schmidt, secretary of the Department, then designated the Division of Health, under supervision of the State Health Officer, to be responsible for the administration of Comprehensive Health Planning functions.

The Division of Health, in turn created a Bureau of Comprehensive Health Planning under the direction of George H. Handy, MD.

The Bureau will be advised by a State Advisory Council for Comprehensive Health Planning whose members are appointed by the Governor for two-year terms.

By federal law, the Advisory Council is composed of a majority of persons who are not primarily engaged in health activities or services.

In Wisconsin, responsibility for advising the Bureau on its health planning activities rests with a 37-member Council, 19 of whom represent consumers of health services. (See page 394 for membership of the Council.)

To date, the Advisory Council has met twice: on April 25 and July 17.

Although the July 17 meeting was billed as a "priority setting" meeting, the task proved too formidable for one sitting. As a result, the Council approved the creation of four technical subcommittees, each to deal with a topic of statewide concern:

1. How should public health be organized, administered and manned?
2. Health services and needs.
3. Health manpower.
4. Feasibility of developing and operating a health data center in Wisconsin.

The task of comprehensive planning is a formidable one. In addition to an estimated 250 to 300 private, voluntary health agencies at the local and state levels, there are at least 25 agencies of state government and a myriad of county-city-town agencies dealing with health.

On top of this, it is estimated that from 40 to 100 different programs of health services stemming from federal sources serve Wisconsin's residents in one way or another.

Advisory Councils Have Prime Planning Role

Although the State Bureau of Comprehensive Health Planning sees its primary role as one of fact-finding, priority-setting and cooperative planning with local areas for the provision of health services in Wisconsin, its "ace in the hole" is a rather substantial influence over the allocation of state and federal monies for health programs and projects throughout the state.

The trump cards will probably not be played for some time. This is because Comprehensive Health Planning is in its infancy in Wisconsin.

After a period of fact-finding, priority-setting, and development of areawide health planning agencies, it is anticipated that the State Advisory Council and the Bureau will incorporate priorities of need in the state plan.

To receive federal aid (or possibly state aid) for health care programs, each areawide planning agency must submit its request to the State Advisory Council.

The State Council may or may not agree with the local agency's views on priority. The areawide Council may ignore the recommendations of the State Council, but if federal funds are involved, the recommendation of the State Council will presumably carry substantial weight with USPHS which has final determination in the granting of federal funds.

State Comprehensive Health Planning director, Dr. George H. Handy, foresees the time when the State Advisory Council will make its recommendations known to the Governor, the Legislature, and other state agencies on matters involving state funding of health care services and programs.

OEO HEALTH CARE FOR POOR IN NORTH WIS.

Two mobile health teams will range a seven-county area of northwest Wisconsin to provide "comprehensive health services" to the poor, under a newly funded OEO program.

Each team will have a mobile van plus a nurse, nurse's aide, driver–coordinator, and several "outreach-referral aides," and an M.D. eight hours per week.

Backed by a $127,000 one-year grant from OEO, the project is under the direction of the West Central Wisconsin Community Action Agency, Inc., directed by J. C. Banks, Menomonie.

The teams will do prescreening to assess needs, refer to appropriate clinics, community education, distribution of preventive materials, pay for hospital services, and the like.

Persons "eligible" for the benefits of the project must reside in Barron, Chippewa, Dunn, Pepin, Pierce, St. Croix, or Polk counties.

Dr. Mason SMS Rep for CHP

"Every Doctor of Medicine should right now be taking interest in Comprehensive Health Planning, and county medical societies should be active in forming local planning agencies," advises Dr. Paul B. Mason, Sheboygan, the State Medical Society's official representative on the State Advisory Council for CHP. He is one of two practicing physicians on the 37-member CHP Council.

Paul B. Mason, MD

SMS Hot Line

HOSPITAL LEADERS are in heated debate over an American Hospital Association proposal that would give area planning agencies veto power over hospital replacement, modernization, or expansion in exchange for "exclusive" service areas and federal financial help. AHA says: "The highest priority must be given to community health care of all the people." One noted hospital administrator says: "I don't see the difference between controls by government or by voluntary agency. . . . I'd rather have someone shoot me than commit suicide." Decision will be reached at AHA convention, Sept. 16-19.

AREAWIDE HEALTH PLANNING meetings will be held from late September to early November at Fond du Lac, La Crosse, Wisconsin Rapids, Green Bay, Eau Claire, and Rhinelander. Sponsor is the Wisconsin Bureau of Comprehensive Health Planning. Purpose is to discuss organization of areawide planning operations. All are open to the public. . . . Local MDs are urged to attend.

MOST WISCONSIN HOSPITALS are part of a massive computer survey to determine the area from which each hospital draws its patients. Data is collected from samples taken in October 1967, March and August 1968. Results will be available about year-end to help plan hospital utilization, designate hospital service areas, and determine nursing home priorities, according to the State Bureau of Comprehensive Health Planning.

WHERE WE STAND TODAY in Regional Medical Planning and Comprehensive Health Planning is the subject of a meeting August 17 of the Executive Committee of the Council of the State Medical Society and Society members who serve on Regional Medical and Comprehensive Planning boards or committees. Following the meeting, the Society is expected to prepare recommendations for possible Council action.

HIPPIE HEALTH and similar topics of youth interest will be the theme of the 1968 Wisconsin Work Week of Health, October 1-4, at the State Society headquarters, Madison. Youth discussion groups will talk with state and national medical leaders on such issues as "pot" and LSD, promiscuity and VD, diets and nutrition, emotional problems of youth and parents, drinking, smoking, safe driving, fads and quacks that prey on youth, and careers for health.

PHYSICIANS ARE BEING VICTIMIZED by a current mail order solicitation throughout Wisconsin. Several doctors have reported to SMS they paid from $45 to $85 for what they thought was a listing in a telephone company Yellow Pages service. Instead they bought "space" in a phony directory.

POSTPAYMENT FINANCING of heath care expenses has been initiated by Wisconsin Physicians Service-Blue Shield. Under the plan, eligible WPS subscribers would be granted ''instant credit'' for needed services not paid for by their WPS contracts. More details next month.

W. D. James, M.D.

PRESIDENT'S PAGE

A Daily Opportunity to "Set the Record Straight"

OVER THE YEARS the medical profession has had its fair share of criticism by the news media and by those agencies who claim to speak for the public. At the recent AMA meeting in San Francisco, the House of Delegates took positive action to alleviate some of the major causes of public dissatisfaction.

One of the public's major frustrations stems from the shortage of doctors. While this situation can in no way be attributed to any act or policy of the medical profession, it has been the tendency of the press and public to accuse doctors of limiting enrollment in medical schools to cut down on the number of new doctors entering practice. The facts are quite to the contrary. No one is more aware of the shortage of doctors than those physicians who are carrying the load of the ever-increasing demand for medical care. For years the AMA has attempted to encourage medical students through generous loans and grants to both individual students and to colleges.

At the annual meeting in June, the AMA joined the National Medical Association and the Association of American Medical Colleges in asking for a massive transfusion of federal and state funds into medical schools, doubling of enrollment, acceptance of all qualified students, and adopting realistic standards in beginning medical courses.

Although the medical profession has often been accused of bias and discrimination, the policy of the AMA has always been to leave membership eligibility to local control—a policy which has much to recommend it. However, at its June meeting, the AMA House of Delegates proposed that the bylaws be changed to permit the AMA to discipline member societies that practice racial discrimination.

The cost of medical care is another area of public concern. Physicians are accused of raising fees unreasonably; however, careful analysis will show that the costs of medical services have risen less than the costs of other services. Recent action of the AMA House of Delegates recommends that a study be made of a plan to finance health care for the needy through some type of insurance mechanism, and that health insurance premiums be used as income tax credits. Physicians are not unmindful of the needs of the poor. They are, however, interested in delivering medical care in the most efficient and economical manner.

There is need for better understanding of medicine's problems and programs. Our state medical society has over 4,000 members. In one average day these members probably see more than 100,000 patients. This is a challenging opportunity for some positive public relations. But first of all every doctor must himself have accurate information about medicine's policies and programs. Only then can he impart to his patients the medical profession's genuine concern for the public welfare—and only in this way can he keep the public's friendship and respect.

W. D. James M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

AUGUST 1968

Vol. 67 No. 8

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Traduction of the Clinical Laboratory

■ AN INTERESTING EXERCISE in the distortion of information by government sources has recently been exposed in the *Bulletin* of the College of American Pathologists. The exposure indicates the techniques used by bureaucrats to euchre funds out of Congress for useless projects.

In the last few months newspaper and magazine articles about the inadequacies of medical laboratories have shocked the public. One present-day muck-raker, Ralph Nader, is using the topic as a follow-up project after his spectacular success with auto safety. Actually, the charges that are being made are more than two years old. They all seem to derive from testimony presented to a subcommittee of the House of Representatives by the Public Health Service to support a budget request for the National Laboratory Improvement Program.

The charges range from allegations of serious deficiencies in the laboratories of the nation to "deplorable quality of work performed by many – –." The PHS testimony indicated that "25% of tests performed are inaccurate" and that "premature death, extended hospital stay, unnecessary suffering, loss of productivity as well as tremendous economic loss (430 million annually) are consequences of inaccurate laboratory results."

If these charges were true, the medical profession, which depends so heavily on the clinical laboratory, would indeed be in a sad way. If these charges were true, every patient should feel terror-stricken at the idea of subjecting himself to therapy which may be indicated by laboratories so inadequate. If the charges were true, the Public Health Service would indeed be justified in asking for huge funds to correct the situation. But the charges are not true.

The original accusations that were made on February 11, 1966, were not documented. As a result of the charges, however, there was formed a seventeen-man ad hoc panel of the National Communicable Disease Center to develop a program to correct a condition in which it appeared that one out of every four test results produced in clinical laboratories was wrong. The report brought back by the Panel

focused the charges, attempted to document them, and in so doing permitted the truth of the matter to be exposed. The sweeping charges were now itemized and the bases for making them were listed so they could be examined. It should be pointed out, in all fairness, that before the report was published three members of the NCDC ad hoc panel questioned the charges of inadequacies in the clinical laboratories of the nation, and one of them even wrote a warning that "none of the quoted figures are true and should not be permitted to pass for the truth."

Examination disclosed that of the twelve references used to support the charges, "five are NCDC surveys, another survey is from New York City, one survey from Canada, and two surveys are 15 and 20 years old respectively." The NCDC surveys involved unrepresentative governmental laboratories such as state health departments, Indian Bureau hospitals and federal prisons, and could by no reasonable logic be extended to apply to active community hospital medical laboratories which handle the bulk of the nation's patients. Thus, in the first instance, the Public Health Service didn't know how good the nation's laboratories were; it only knew about government operated labs. And it is unfair to imply that a rate of error established for laboratories of a limited, unrepresentative character is true of all labs in the country.

To use data taken from a foreign country and from a single locality to characterize the laboratories of the entire United States is also obviously unfair, just as it is pointless to refer to a situation that was corrected years ago—unless you are looking for government funds to correct it all over again. It is also unfair not to cite more recent data that proves that the College of American Pathologists has taken measures to police clinical laboratories, and that the measures have been remarkably successful in establishing standards that have reduced the percentage of error to a non-significant minimum.

In addition to tendentiously unfair use of sources to support grossly exaggerated charges, the Panel report was guilty of a "mistake" in arithmetic. It alleged that 50,000 to 250,000 transfusions of mismatched blood occur each year—enough to terrify any potential recipient of blood, if it were true. Again, it isn't true. The correct calculation of error, on a basis of five million pints administered, would be 5,000 to 25,000 pints, and even though corrected the lower figures rely on data between 20 and 30 years old. Current information developed by the College of American Pathologists shows an error from 0.03% to none at all in sizable test samples. The current comparable figure for incidence of hemolytic transfusion reaction would range from 500 to 1500 per five million pints administered.

Spectacular charges, such as those made about clinical laboratories, have a life of their own, and no matter how little understood they are or how tenuous their relation to fact they persist, to surface in the murky apprehension of patients or in the memory of those hostile to the medical profession. When confronted with these charges or the distortions derived from them, physicians should inform their patients of the truth. The demonstrable record is that quality control procedures were begun in medical laboratories in hematology, histopathology and serology in the third and fourth decades of this century in the United States. Standards were established for blood banking in the 1940s and in clinical chemistry in 1950. The truth was stated by Dr. Ernest E. Simard, former president of the College of American Pathologists, who advised the Senate Subcommittee on Health of the Committee on Labor and Public Welfare last September that "when medical usefulness is used as an evaluation criterion, more than 95% of laboratory tests in the United States are acceptable and support correct medical decisions. A test report which leads to medical mismanagement is a rarity."

Truth is the only effective defense against government sponsored double-think. When doctors give truth as much currency as false allegations and misstatements regarding the medical profession, they will be performing a great service to their calling and to their patients. It is in the interest of all medical personnel to write to the College of American Pathologists, 230 North Michigan Avenue, Chicago, Ill. 60601, for a reprint of the article "Clinical Laboratory Performance" that appeared in the *Bulletin*, Vol. XXII, No. 2, February, 1968, which describes in detail this amazing government sponsored perversion of the facts concerning clinical laboratories.

—D.N.G.

LETTERS

SPEARS CHIROPRACTORS OF DENVER

To the EDITOR:

I think many Wisconsin doctors have been concerned about the misleading advertisements sent out to Wisconsin people by the Spears chiropractors of Denver, Colo.

I sent out the editorial about this published in our monthly journal awhile back (Postal Abuse: March 1968) and sent it to Senator Nelson asking why no action was taken by his committee or the government agencies on such fraudulent ads?

I'm enclosing (see below) his answers and I don't quite agree that the FDA etc. hands are as tied as it appears if proper investigation was made, but I'll leave that decision up to others to make. Perhaps some of our Wisconsin doctors may like to express their views directly to Senator Nelson on this?

For some reason the politicians seem afraid to tackle the chiropractors when they seem to have no lack of courage in attacking drug firms. What's the reason?

ROBERT G. ZACH, M.D.
Monroe, Wisconsin

To DOCTOR ZACH:

I am enclosing two letters I have received concerning my inquiry regarding the Spears Free Clinic and Hospital for Poor Children, Inc., of Denver, Colorado. As you know, I asked the Post Office Department and the Food and Drug Administration to comment on the article in the *Wisconsin Medical Journal* which you sent me.

The Food and Drug Administration, as you will see, indicates that the clinic would come entirely under state regulation except for any activity which involved interstate commerce. At one time, apparently, a device which had moved in interstate commerce was seized under the misbranding provisions of the Federal Food, Drug and Cosmetic Act. However, FDA states that they have not encountered any further interstate activity on the part of the Spears Hospital.

The Post Office Department replies that they have previously investigated the mailing activities of the Spears Clinic but did not develop sufficient evidence to warrant action under the mail fraud statutes. Unless you have further evidence, I am afraid there is nothing further I can do at this time to urge a further investigation by the Post Office Department.

I do think it is helpful, however, to continue calling this clinic to the attention of the FDA and the Post Office Department so that they are on the alert for any further inappropriate activity on the part of this clinic. You might want to contact the Colorado medical societies to share with them a copy of the *Wisconsin Medical Journal* article also.

GAYLORD NELSON
U. S. Senator

To SENATOR NELSON:

There has been referred to this Bureau your letter of April 30, 1968, enclosing a clipping from the *Wisconsin Medical Journal*, which was sent to you by Dr. Robert G. Zach of the Monroe Clinic. The subject article relates to the Spears Free Clinic and Hospital for Poor Children, Inc., Denver, Colorado, and indicts the Post Office Department for allegedly permitting the distribution of deceptive and misleading literature which the Clinic is mailing at the third-class rate of postage.

The sentiments expressed in the subject article are, of course, fairly well understood by this Service as we are aware of the friction that has existed for many years between the medical fraternity and those who practice and follow the chiropractic theory. Nevertheless, because of complaints made relative to the mailing activities of the Spears Clinic several years ago, an investigation was conducted by this Service but there was not developed sufficient evidence to warrant action under the mail fraud statutes. Numerous editions of the Spears Sanigram have since been received in the Department but they were found quite similar to those which were considered at the time of the investigation.

As you are aware, the sole purpose of investigating cases relating to the alleged fraudulent use of the mails is to present the evidence to the United States Attorney for consideration of criminal prosecution under the mail fraud statutes, or to the General Counsel for the Post Office Department for consideration of denying the accused the privilege of receiving mail. Until evidence supporting such action is presented, therefore, and in the absence of widespread complaints against the clinic, it is our judgment that further investigation is not warranted at this time.

The publication in question may seem highly objectionable to a certain segment of the population; however, so long as the mailing activities of the organization remain within the framework of the law, to exclude such matter arbitrarily would raise serious constitutional questions involving the mailer's right to disseminate information and to conduct an enterprise by means of the mails. The Supreme

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

Court stated in *Milwaukee Pub. Co.* v. *Hurleson*, 255 U. S. 407, "The United States may give up the Post Office when it sees fit, but while it carries it on, the use of the mails is almost as much a part of free speech as the right to use our tongue."

We appreciate the opportunity of responding to the article, and if we can be of further assistance please do not hesitate to contact us. Thank you for bringing this matter to our attention.

H. B. MONTAGUE
Chief Inspector
Post Office Department
Washington, D.C.

To SENATOR NELSON:

This replies to your request of April 30, 1968, enclosing a copy of an article from the *Wisconsin Medical Journal*, sent to you by Dr. Robert G. Zach.

The author of the article, in speaking out on the Spears Free Clinic and Hospital for Poor Children, Inc., Denver, Colorado, a chiropractic institution, wonders why Federal agencies, such as the Food and Drug Administration and the Federal Trade Commission, "are so indifferent when it comes to the misleading statements of the chiropractic cultists."

Our investigations, on several occasions, indicated that the Spears organization requires patients to come to its establishment at Denver for treatment. We have not encountered any drugs or devices distributed in interstate commerce by the Spears Hospital, and therefore, we have no jurisdiction over the activities of the Hospital.

Several years ago, we encountered a device known as the "Neuromicrometer" in use at the Spears Hospital which we concluded was misbranded because of false and misleading claims of effectiveness in diagnosing and treating serious disease conditions. We instituted seizure action against the device under the misbranding provisions of the Federal Food, Drug, and Cosmetic Act. The "Neuromicrometer," had been manufactured in Utah and was subject to the Federal law because it had moved in interstate commerce.

As you know, regulation over the practice of medicine and the licensing of practitioners of the healing arts, hospitals, etc. under the Medical Practices Act of the State is a function of the State authorities, not the Federal Government.

PAUL A. PUMPIAN, Director
Office of Legislative and Governmental Services
Department of Health, Education and Welfare
Food and Drug Administration
Washington, D.C.

To SENATOR NELSON:

This is in further response to your letter of April 30, 1968, enclosing a copy of an article which appeared in *The Wisconsin Medical Journal* sent to you by Dr. Robert G. Zach of the Monroe Clinic, regarding the Spears Free Clinic and Hospital for Poor Children, Inc., Denver, Colorado.

On several occasions during the past we have considered the advertising of this institution which previously operated under the name of Spears Chiropractic Hospital. It is our conclusion that the Commission has no jurisdiction because the hospital is not engaged in the sale of shipment of a food, drug, device or article in interstate commerce.

It would appear that this matter would be more appropriately handled by referral to the public health authorities in the State of Colorado.

JOSEPH W. SHEA,
Secretary and Congressional Liaison Officer.
Federal Trade Commission
Washington, D.C.

MEMORIAL STATEMENT OF THE COUNCIL ON HEALTH IN MEMORY OF JOHN H. HOUGHTON, M.D. A MEMBER OF THE COUNCIL ON HEALTH

It is with deep sorrow and regret that we record the untimely passing of our fellow member of the Council on Health. Dr. John Houghton of Wisconsin Dells served the citizens of the State of Wisconsin faithfully and with great interest and zeal in protecting the welfare and health interests of our citizens as a private practitioner and a member of the Council.

May it be recorded in the minutes of this Council so that these facts will be preserved for posterity. It is with humble appreciation that this Council express its personal gratitude for his efforts on behalf of the citizens of Wisconsin and this Council.

May it be requested that a copy of this Resolution be sent to his bereaved family and to the State Medical Society of Wisconsin for recording and recognition.

—Official Statement of the Council on Health
May 3, 1968

THE MEDICAL STUDENT FORUM

Devoted to the expressions of the medical students at the University of Wisconsin and Marquette medical schools through association with the Student American Medical Association. A feature originated by the State Medical Society of Wisconsin to stimulate closer relationships with the physicians of tomorrow. This space is offered monthly to both schools on an alternating basis, with copy deadline the first of the month preceding the month of publication. Statements and opinions contained herein are those of the students.

AUGUST 1968

SINCE SAMA is a comparatively new organization (less than 20 years old), I would like to inform our readers of some of its functions. In the February issue Bruce Buchanan presented a general overview of national SAMA; this month's page will be devoted to local functions, especially those of SAMA–Marquette.

One of the major functions of the Marquette chapter is to welcome incoming freshmen and set up a big brother program. This is handled in two phases. During summer each freshman receives a letter explaining SAMA and telling him who his "big brother sophomore" is. Then, after the school year has started, SAMA sponsors a welcome banquet for the freshmen. This banquet is made possible through the generosity of local physicians and faculty members. This serves as a time when the freshmen can meet their "big brothers." Big brothers are expected to aid the freshmen in the hurried and hectic first few months of medical school and to acquaint them with procedures, classes, and teachers.

BIG BROTHER PROGRAM

Another function in the fall is the SAMA–Ball. This is a semi-formal social affair held at one of the Milwaukee ballrooms. At Marquette, SAMA doesn't sponsor other social events since the two medical fraternities cover further social events.

In the spring of the year SAMA sponsors and runs the Medical School Career Day. This has proved an opportunity for high school and college students to preview the various areas of the medical sciences. In addition to general medicine the fields of physical therapy, medical technology, and nursing are covered at career day. As reported in the April issue of the *Wisconsin Medical Journal,* we have found that career day is both enjoyed and helpful to those thinking about a future in the medical sciences.

SAMA–Marquette also aids in the publication of the *Medical School News*. This is a paper, published throughout the school year, which serves as a means whereby students can express their opinions on medically related issues. Recently the paper has been active in student surveys on subjects ranging from health care for the poor to methods of teaching and the various required basic science subjects.

MEDICAL SCHOOL NEWS

SAMA also sponsors weekly films on current and/or important medical concepts. In addition an effort is made each year to obtain a speaker in some interesting and often controversial area of medicine.—JOHN E. INMAN, President, SAMA–Marquette.

* * *

AFTER EIGHTEEN YEARS as executive director of the 60,000 member Student American Medical Association, Russell F. Staudacher, 53, of Park Forest, Ill., retired as of June 30. Mr. Staudacher will be succeeded by 28-year-old Charles Hewitt of Kansas City, attorney and administrative assistant of the American Academy of General Practice, who will assume his new responsibilities in mid-August. Mr. Staudacher, who suffered a heart attack last December, was named executive director emeritus of SAMA and will serve as a consultant to several other organizations as well during his retirement.

Mr. Staudacher came to SAMA in May 1951, soon after the founding of the organization in December 1950. In his years with the association, the medical student, intern, and resident group grew from 21 medical school chapters to 91 affiliated chapters as of the recent 18th annual meeting in Detroit.

NEW HEAD FOR SAMA

SAMA's new executive director was selected from a field of 72 applicants and comes to his new duties well qualified to lead the "new and socially conscious" SAMA to still further progress in the field of medicine. Mr. Hewitt is a native of Pratt, Kan., and a graduate of the University of Kansas with an AB degree and his law Juris Doctorate coming from the School of Law at the University of Kansas. In law school he was president of the Student Bar Association and active in the affairs of the Law Student Division of the American Bar Association.

* * *

DANIEL E. HATHAWAY of Wauwatosa has been awarded a $1,000 scholarship for the 1968–1969 school year by the University of Wisconsin Medical School, it was announced by Peter L. Eichman, M.D., Dean.

A graduate of Williams College in 1965, Mr. Hathaway is a member of the class of 1969 at the University of Wisconsin Medical School. He was awarded the scholarship by school authorities on the basis of academic qualifications.

The scholarship was made available by the Pfizer Laboratories Division, which markets a wide range of ethical pharmaceutical products. A similar scholarship provided by the division is also available at all 99 medical schools in the United States.

the wisconsin medical journal

VOLUME 67/NUMBER 9 SEPTEMBER 1968

Superior Mesenteric Arterial Embolectomy

Report of a Case with Survival

By WILLIAM M. STOLL, M.D., Green Bay, Wisconsin

■ SUPERIOR MESENTERIC arterial embolism is an infrequent but serious entity. Early diagnosis is difficult and the outcome usually has been fatal. Recently, however, embolectomy has been performed with greater success. The following report describes a case of superior mesenteric arterial embolism in which embolectomy could be carried out. The outcome was successful.

Case Report

The patient was a 69-year-old white woman who was admitted to the hospital in October 1965. She developed acute, sudden, severe mid-abdominal pain while eating breakfast. The patient became semicomatose, pale, cold and clammy, and was brought to the hospital emergency room approximately one hour after the onset.

Examination revealed an elderly, obese, pale, cold and clammy woman with a low blood pressure. She complained of severe, diffuse, constant, mid-abdominal pain. No history of previous cardiac or gastrointestinal disease was obtained. The heart rate was regular at 130, and the lungs were clear. The abdomen was not distended but was diffusely tender. Bowel sounds were present and the rectal examination was normal. Laboratory studies revealed a white blood cell count of 8,000 with a shift to the left. Urinalysis was normal. Transaminase, serum amylase, and electrocardiographic studies were normal. A chest roentgenogram was normal, but abdominal x-ray films revealed an absence of gas pattern.

The initial impression was superior mesenteric arterial embolus. Delay in surgery was recommended primarily because the condition was of only one-hour duration, and there were no known sites for the origin of the embolus since the cardiac rate was regular and there was no previous history of myocardial infarction. The severe abdominal pain gradually subsided, blood pressure returned to normal, the patient became warm, and her color improved. The white blood cell count increased to 13,700 and then to 22,500, with shifts to the left, within four hours after admission.

Surgery was carried out approximately six hours after admission. The small bowel was dusky with one portion of the mid-jejunum nonviable. The superior mesenteric artery was isolated and controlled proximally and distally. The embolus could be palpated at the bifurcation. A longitudinal arteriotomy was performed and an organized embolus was removed. No back-flow of blood was seen. The distal thrombi were "milked" and suctioned out; and a good back-flow of blood was obtained. The arteriotomy was closed with fine Mersiline suture without a roof-patch graft. Good arterial flow was reestablished and the distal mesenteric branches pulsated. An 18-inch segment of nonviable mid-jejunum was resected. The remaining portions of small bowel and proximal right colon were viable. The postoperative course was routine except for a continued high white blood cell count (19,000) 48 hours after surgery and also a temperature of 101 F.

A second-look operation was carried out to rule out further bowel necrosis. The bowel was viable and the abdomen was closed. The patient had an uneventful postoperative course and was discharged about two weeks after surgery.

Comments

Prior to the development of successful embolectomy, the mortality accompanying superior mesenteric artery occlusion was about 90%.[1] In 60 cases of superior mesenteric artery occlusion reported from the

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Mayo Clinic,[2] 19 were secondary to emboli and potentially correctable.

Since the first successful superior mesenteric artery embolectomy performed by Shaw[3] in 1957, there have been a total of 17 successfully treated cases summarized by Kreager.[4]

Prompt recognition of the syndrome of mesenteric artery embolic occlusion allows successful correction. The sudden onset of symptoms may differentiate this condition from mesenteric thrombosis. Embolic occlusion is classically prostrating and sudden in onset. Thrombotic occlusion mimics small bowel obstruction with slow progression.

The delay in performing surgery in the case presented could have been serious. Surgery was delayed primarily because no detectable source for an embolus could be determined. It is conceivable that the embolus originated from this patient's abdominal aorta since a marked degree of atherosclerosis was present in the aorta. The embolus also could have arisen from a left ventricular mural thrombus due to an old and unrecognized infarction.

Summary

A case of superior mesenteric arterial embolectomy is presented. Prompt diagnosis and immediate surgery are stressed.

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FAMILIAL POLYPOSIS OF COLON

V. S. Falk, MD, Edgerton, Wis., and J. C. Thomas Rogers, MD, Urbana, Ill.: *Arch Surg* 96:967–969 (June) 1968.

In 1942, V. S. Falk, MD, now of Edgerton, Wisconsin, and J. C. Thomas Rogers, MD, of Urbana, Illinois, reported in *Archives of Surgery*, a family of seven children, six of whom had polyposis of the colon. Now, twenty-five years later, a follow-up study of the same family was published in the June 1968 issue of *Archives of Surgery*.

Nineteen members of the family have been studied. The father of seven children died of carcinoma of the rectum at 48 years of age. It is also of interest that his father had died at an early age of "cholera morbus." In the original study in 1941, when six of the seven children were found to have polyposis of the colon, three were males and three were females. Four (three men and one woman) have died of carcinoma of the rectocolon at ages 28, 29, 30, and 33. Three of the deceased had inadequate surgical procedures carried out before the family came to the attention of the authors, and the fourth deferred surgery until only a palliative procedure was possible. Two of the patients had adequate surgery (at ages 24 and 22) and are still alive and well. Carcinoma in situ was found in the younger.

The six with disease have had a total of seven children. Four of the seven in this generation have been found to have the familial disease: one woman, now 30 years old, had a colectomy at age 16; a second woman, now 22 years old, had a colectomy at age 12; a third girl, aged 17, has had a colectomy and carcinoma was found; and a fourth girl, aged 16, has polyposis and surgery has been advised. There are three children, two girls and one boy, free of disease.

Of the original generation, the one member who was free of disease has had five children. All of them are also free of disease. The overall figures for the 19 studied are nearly equally divided (10:9) between disease and free of disease. However, an in equity exists because the one sibling who was free of disease in the original study has had five children, all free of disease. Thus two-thirds of the nine without disease are all in one segment of the family. This is consistent with the reports of other authors that all of the children of these parents, not affected, were free of the disease.

Common signs and symptoms of familial or congenital polyposis include diarrhea, intermittent blood in the stools, abdominal cramping, weight loss, or anemia. Polyps may be palpable in the rectum, but sigmoidoscopy and roentgen examination of the colon establish the diagnosis and reveal the extent of the disease. Early colectomy is the accepted treatment. Preservation of the sphincter is possible in those patients who will adhere to rigid follow-up with inspection of the residual rectum and fulguration of new polyps.

The conclusions the authors made in 1942 still appear valid: the type of polyposis presented in these cases is a hereditary condition; malignant degeneration of the polyps is frequent in cases of polyposis of the colon; early and radical operation is the treatment of choice.

GRANULAR CELL MYOBLASTOMA

Report of Three Cases in the Chest Wall and Review of the Literature

By DAVID B. APFELBERG, M.D. and JACK L. TEASLEY, M.D.
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■ GRANULAR CELL MYOBLASTOMA is an uncommon but not rare tumor of subcutaneous tissue. Since the first description, over 400 cases have been collected in the world's literature. Widely varied locations have been described, the most common being the tongue (approximately 40%) and the skin, muscle, and subcutaneous tissue (approximately 30%).[1] Other locations cited in order of decreasing frequency by Wagner[2] are: the lip, larynx and bronchial tree, breast, female external genitalia, and skeletal muscle. Many authors have described bronchial lesions;[3-7] tongue lesions;[8-10] gastrointestinal lesions, including the stomach,[1] esophagus, colon, and common bile duct; and neural lesions of the neurohypophysis.[11]

This report will review the clinical and histopathological aspects of granular cell myoblastoma and present three cases of chest wall lesions in males.

Case Reports

Case 1.—A 37-year-old Negro man complained of a mass in the left lower anterior chest wall area. He thought the mass had been present about six months and was slowly enlarging. There was no pain except when pressure was applied on the area. Examination revealed a freely moveable, nontender, firm, 4 to 5 cm, irregularly shaped subcutaneous mass on the lower left anterior chest in the paraxiphoid area. The preoperative diagnosis was fibroma. Local excision revealed a firm pale whitish-gray mass adherent to overlying skin and extending into adjacent tissue. Microscopic appearance included large polyhedral cells with a cytoplasm containing coarse eosinophilic granules. These cells were closely associated with adjacent nerve bundles. The diagnosis was granular cell myoblastoma (Figs 1 and 2).

Case 2.—A 38-year-old Negro man presented with a 1 x 1 cm freely moveable nontender subcutaneous mass in the left breast present for two years. This was unattached to the areola or underlying muscle. After excision, the lesion was noted to contain a predominance of adipose tissue with multiple fibrous bands and zones of firm tissue diffusing through it. Microscopically, cords and columns of cells with coarsely granular eosinophilic cytoplasm consistent with granular cell myoblastoma were described.

Case 3.—A 45-year-old Negro man presented with two subcutaneous masses, one in the left anterior chest wall area, and one in the left submandibular area of ten years' duration. Two granular cell myoblastomas had been removed from the umbilicus and para-umbilical region eight years prior to the present admission. Excision revealed a 3½ x 4½ cm hard white homogeneous mass attached to the underlying pectorilas muscle fascia. Also excised was the smaller submandibular mass. Sections of both lesions revealed elongated cells with a granular eosinophilic cytoplasm consistent with the diagnosis of granular cell myoblastoma (Fig 3).

Comment

Granular cell myoblastoma has been reported by Wagner[2] to occur most frequently in the third to fifth decades. Males and females are affected equally. Only three to four percent of patients with granular cell myoblastoma have multiple lesions[1, 12, 13] as in case 3. Three percent of myoblastomas have evidence of malignancy designated as granular cell myoblastosarcoma. Otherwise the lesion is benign and local excision suffices with very rare recurrences.

The pathology consists, grossly, of firm gray-white nodules often without well circumscribed edges and with irregular extensions into adjacent tissues. Microscopically, there are nests and cords of large polyhedral cells of uniform shape. The faintly staining cytoplasm contains the characteristic eosinophilic granules. There is often a close association between the tumor cells and

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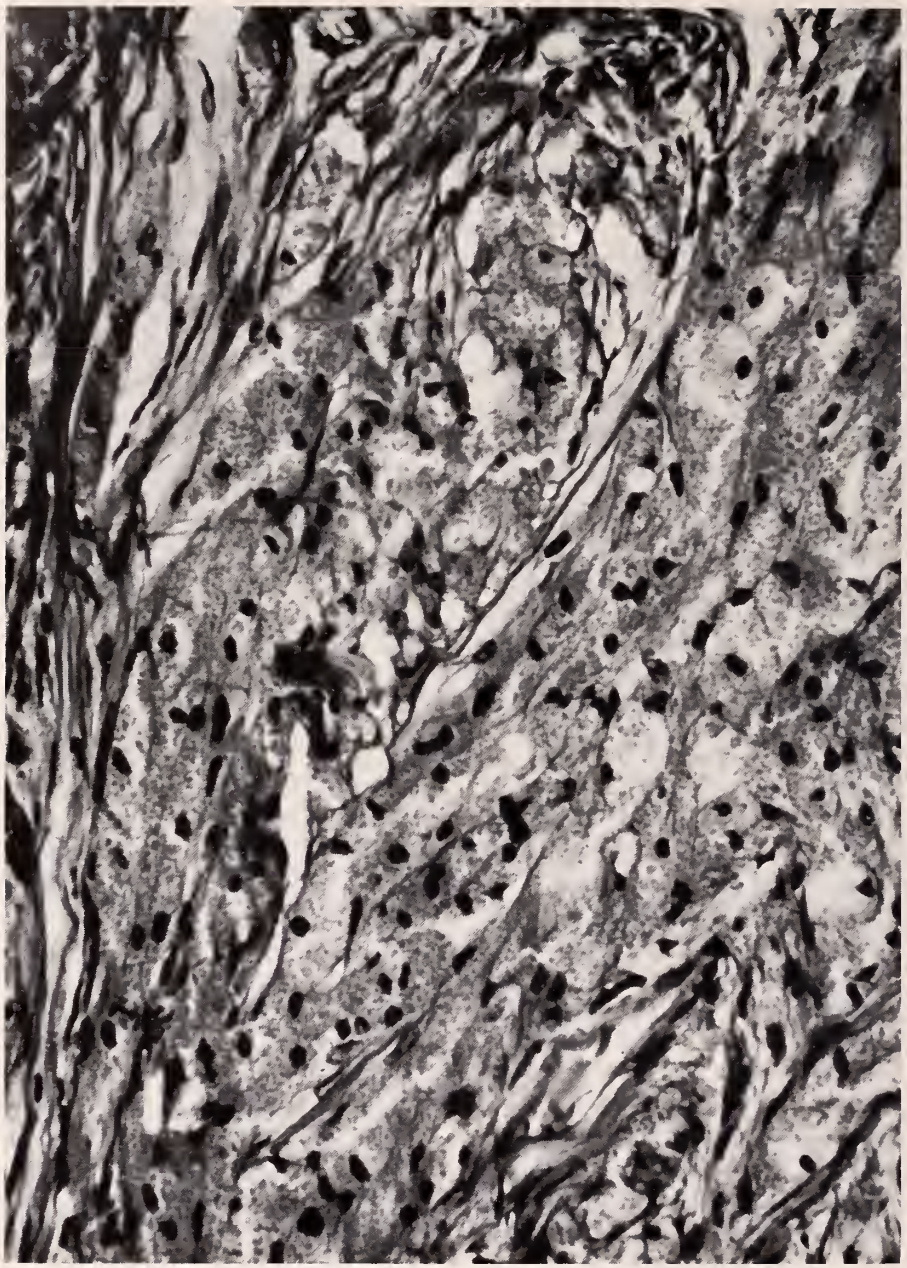

Fig. 1—This low-power (40 X) illustration shows the typical large polyhedral cells in a cytoplasm with eosinophilic granules.

peripheral myelinated nerves.[14] There is also present a moderate amount of collagenous stroma with fine and coarse connective tissue fibers running in all directions. Azzopardi[15] has carefully studied the granules by histochemical techniques and reports that they contain primarily lipid and protein without glycogen or myelin.

Colberg et al[14] as well as Wagner[2] have described a characteristic pseudo-epitheliomatous hyperplasia of the skin overlying some subcutaneous lesions. This unusual occurrence contrasts with the atrophy most commonly found overlying deeper lesions. This hyperplasia may closely resemble squamous cell carcinoma.

Many theories of histogenesis have been offered for granular cell myoblastoma. Colberg[16] has reviewed the various theories of derivation as follows: adult or embryonal muscle cells, neural sources such as Schwann cells or endoneural fibroblasts, fibroblasts,

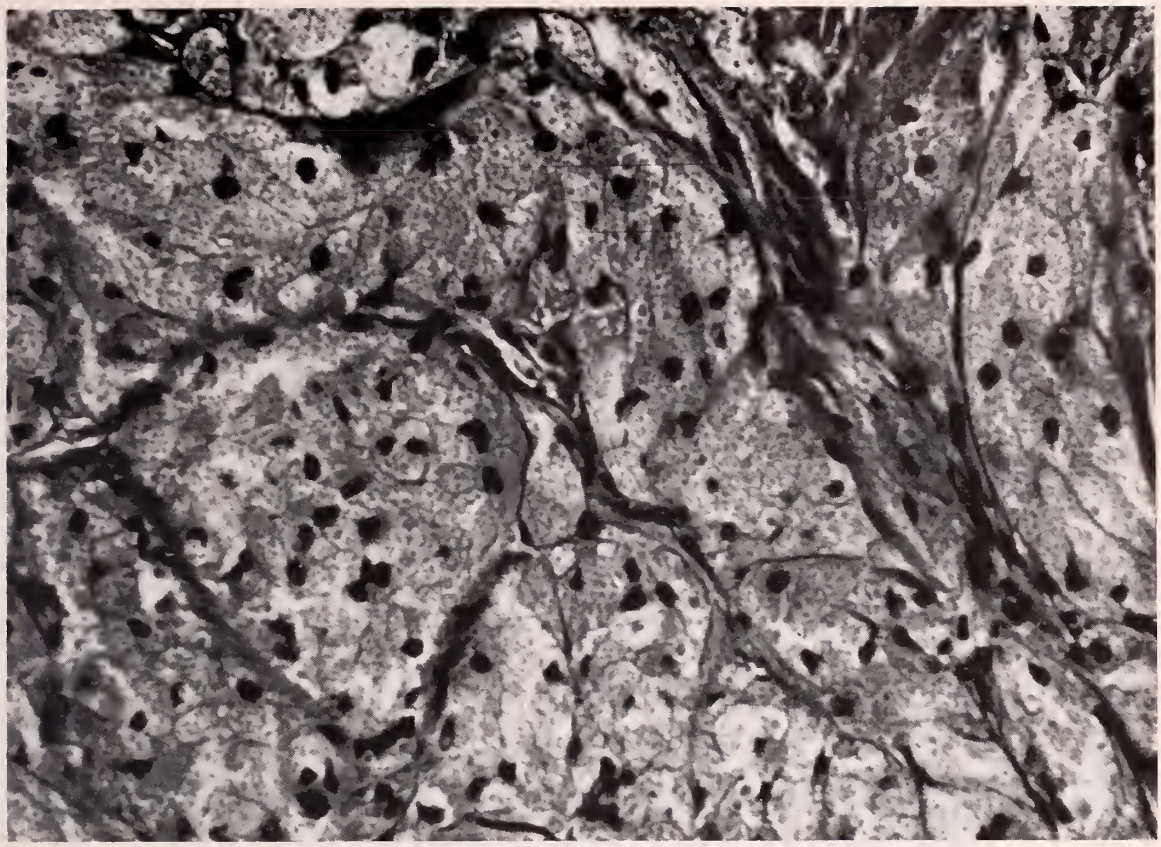

Fig. 2—This illustration at 250 X magnification demonstrates again coarse granular cells in the cytoplasm of large polyhedral cells.

non-neoplastic products of trauma degeneration or regeneration, mesenchymal cells, and storage cell phenomenon. The neural origin has been most commonly accepted. Sobel et al[17] have pointed out that granular cells are widespread in the body, and Doron et al[11] have found myoblastomatous cells in 5.7% of the neurohypophyses that they have studied.

Summary

Three cases of granular cell myoblastoma of the chest wall of males are described. All presented as subcutaneous masses and were locally excised without recurrences. The histology of faint-staining cytoplasm with characteristic granules combined with myelinated and connective tissue cells is reviewed. One case describes the first report of umbilical granular cell myoblastoma.

Granular cell myoblastoma is seldom diagnosed preoperatively, but the surgeon should be aware of this entity and its characteristics in dealing with excisions of subcutaneous masses.

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Fig. 3—The gross appearance is a homogeneous grey—tan firm mass. The cut surface is demonstrated.

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CASE REPORT

Removal of a Giant Hairy Nevus and Coverage of the Resultant Defect with a Meshgraft

By EDMUND B. JACOBS, M.D., Madison, Wisconsin

■ AFFLICTION WITH A giant hairy nevus causes the patient to suffer not only from a significant cosmetic defect but also burdens him with the future possibility of development of malignant melanoma. In the past, the size of this entity frequently caused the physician justified hesitation in attempting to remove the lesion because of the enormous residual defect, and the necessity of covering the defect with split thickness grafts from a limited donor site. However, with the advent of the meshgrafter, the task set before the physician, when he is confronted by a patient with a giant hairy nevus, is not nearly so formidable. The following case report concerns a patient with a giant hairy nevus, the removal of the nevus, and the coverage of the resultant defect with a meshgraft.

Case Report

An 11-year-old white girl was seen early in 1967 (Fig 1). The patient was born with a giant hairy nevus that covered most of her torso. The nevus increased proportionately with the child's general body growth. Although the patient did not seem to demonstrate much anxiety over the presence of the lesion, her parents were quite concerned with it and wished to have it removed. They stated that in the past they had seen two plastic surgeons who refused to remove the lesion because of its size.

Because of recent experience in our department with the meshgrafter in coverage of burns, and because of the reported incidence of melanoma arising in giant hairy nevi, it was felt that an attempt to remove the lesion should be carried out. The patient was therefore admitted to the hospital. On physical examination the patient demonstrated no abnormalities with the exception of the nevus, which extended posteriorly from the mid-cervical region to the sacrum. In addition, it wrapped around the patient's body and involved both sides of the torso and a considerable portion of the anterior abdomen and chest bilaterally.

It was decided that the lesion should be removed in three stages. The first stage would involve removal of the nevus that covered the patient's back; the next two stages would be the removal of the lesion covering both sides and the front of the patient's body.

At operation the major portion of the nevus was removed. Because the nevus extended down to the muscles of the back, it was necessary to remove all tissue superficial to the fascia covering the back muscles. Two units of blood were lost and replaced. The defect was immediately covered with meshgrafts (Fig 2). Donor sites were the patient's thighs and buttocks. The patient was placed in a bulky dressing and taken to the recovery room. During the patient's postoperative course, her progress was remarkable. She had no difficulty whatsoever with her intake and output. She began eating regular meals on the second postoperative day. On the fourth postoperative day, the patient's dressings were changed and 100% of the grafted skin was found to be viable. The remainder of the patient's postoperative course was completely unremarkable. She was discharged from the hospital on the 18th postoperative day. At this time, complete closure of the excised area had occurred.

About five months later she was readmitted to the hospital for further surgery. The previously grafted area was well healed. The nevus covering the left side and anterior portion of the chest and abdomen was excised. No blood was replaced due to minimal loss. The defect was again covered with the meshgraft. Her postoperative course was uneventful, and she was discharged from the hospital on the 13th postoperative day.

One month later the patient was again admitted to the hospital and the remainder of the nevus on the right side and right anterior portion of the chest and abdomen was removed. At this hospitalization, the patient was discharged on the 11th postoperative day. The grafts were completely healed one week following discharge from the hospital.

The patient was very happy with the results of her graftings (Fig 3), and according to the mother,

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Fig. 1—An 11-year-old girl with a giant hairy nevus covering most of her torso.

Fig. 2—Meshgraft covering of the defect.

Fig. 3—Results of meshgrafting.

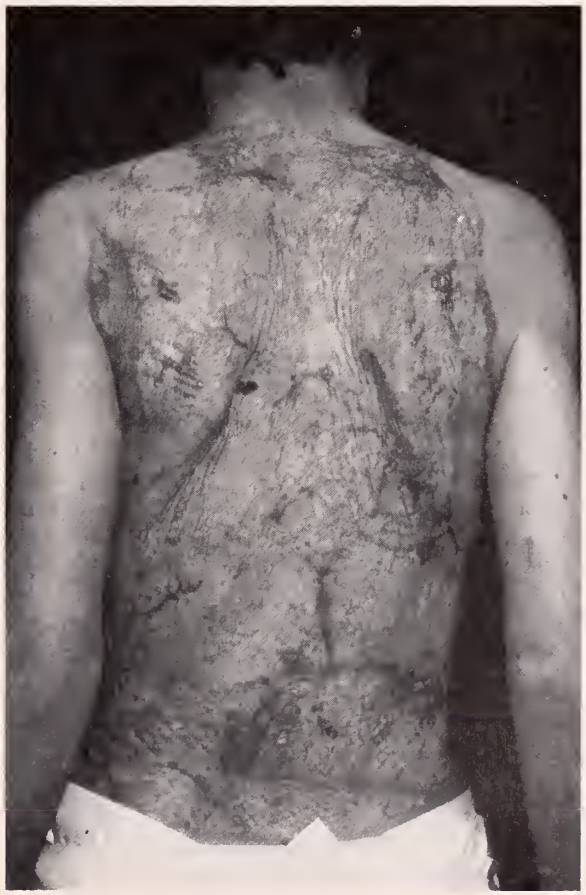
she is now considering wearing a swimsuit and participating in gym classes in school, activities in which she had never before participated.

Discussion

Giant pigmented nevi were felt to be purely cosmetic problems because of the teachings of Spitz.[1] However, Greeley et al[2] in 1965 reported the development of six malignant melanomas in 56 personal cases of giant pigmented nevi. This proved to be an incidence of over 10% development of malignant melanoma from a giant hairy nevus. In addition, Russell and Reyes,[3] in 1959, reported the development of melanoma in giant hairy nevi in over 13% of patients in their series of 53 cases.

The definition of a giant hairy nevus is determined by the amount of body surface covered by this lesion. According to Pilney et al[4] a lesion in the face is designated as a giant hairy nevus if it cannot be removed without leaving distorted features on closure of the defect with adjacent tissue. Greeley et al[2] feel that any lesion in the trunk or extremity with an area greater than 144 inches square is to be considered a giant nevus.

Pathologically, the giant hairy nevus is nearly always an intradermal or compound nevus. These lesions are frequently found in



conjunction with multiple smaller nevi, lipomas, fibromas, and cafe au lait spots. The histological features include an epidermis that demonstrates hyperkeratosis and occasionally parakeratosis. The most distinctive histological feature of the nevus is the epidermal change found in the basilar layer which is not uniformly palisaded as in the normal skin. The continuity of the basilar layer is interrupted by scattered cells or groups of cells which are irregularly enlarged and distended by uniform fine brown granules. Loss of cohesion between these abnormal cells and adjacent cells of the epidermis is present. Spitz[1] stated that frequently it is difficult to distinguish between the histological appearance of these lesions and the histological appearance of a melanoma.

Not only because of the cosmetic defect from which the patient suffers when afflicted with this lesion but also because of the high incidence of malignant degeneration, removal of these lesions seems to be indicated. Ideally, the treatment is surgical excision. In the past, however, the question arose as to how, in many cases, the enormous defect left by the removal of the lesion could be closed. Previously it was necessary to remove the lesions in small amounts, thus necessitating multiple surgical procedures with inherent anesthetic and surgical dangers. The answer to these problems facing the surgeon may be found with the meshgrafter.[5] This instrument uses skin cut with any of the standard dermatomes and forms a mesh from the graft by cutting numerous short parallel slits in the sheet graft. Alternate rows of slits are offset to allow expansion. The meshgraft is used advantageously in the treatment of extensive burns when a large area of granulation tissue necessitates coverage by small areas of unburned donor sites.

Passing a segment of skin through a meshgrafter allows expansion of the skin up to three times its original surface area. In addition to the increase in surface area, advantages of the meshgraft are: (1) complete drainage, (2) rapid epithelization, and (3) conformation to irregular areas. Because skin is lost, primarily, due to the development of hematoma and tissue exudates under a sheet graft, loss of skin is mitigated by the multiple small holes of the meshgraft, which allow drainage of blood and tissue juices. Rapid epithelization of the graft takes place, because of the greatly increased skin edge exposure, and frequently in 7 to 10 days the area to which the meshgraft is applied is completely epithelized. The meshgraft in addition conforms to irregular surfaces such as the breast, neck, ankle, axillae and popliteal areas, and thus does not allow the accumulation of fluid underneath it because of this ability.

In this patient, it was obvious that all of the advantages of the meshgraft could be used to cover a large defect left by the removal of a giant hairy nevus. The patient exhibited a remarkably benign postoperative course following each of her operative procedures. This smooth postoperative course can largely be credited to the use of the meshgraft, which allowed a large defect to be covered by a relatively small amount of skin.

Summary

A case report of a giant hairy nevus is presented. Its removal in the past would have been faced by the surgeon with trepidation because of the amount of skin graft necessary to cover the resulting defect. However, the use of meshgrafted skin allowed an almost insurmountable problem to be overcome. This not only alleviated an alarming cosmetic problem in this patient but also obviated the possibility of future malignant degeneration.

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CYCLE INJURIES

A Comparative Study

By ERNEST A. PELLEGRINO, JR., M.D., Madison, Wisconsin

■ MOTORCYCLE TRAUMA is an area of medicine which like the Vietnam war takes its toll from today's young people. The Madison campus of the University of Wisconsin with its 32,000 students provides an excellent environment in which to study the results of this type of trauma.

The popularity of motorcycles as a means of transportation and pleasure is a natural for university students who are fun-loving, economy-minded, and protest-inclined. Because bicycles are also commonly used by students, faculty and their dependents, a simultaneous study of injuries resulting from both bicycle and motorcycle accidents from Jan. 1, 1965, to Sept. 1, 1967, as seen at the University Hospitals was undertaken. The patients all came to the Emergency Room where they were evaluated, treated, or admitted to the hospital. During this same period some 22,000 patients had been registered in the Emergency Room records for a multitude of complaints of which cycle injuries represented only a small portion. These data do not represent the true morbidity from cycle accidents in the University population as the patients frequently go or are taken to the nearest hospital which may be one of the several other city hospitals.

The total number of patients treated for motorcycle trauma was 440 in contrast to 177 patients treated for injuries resulting from bicycle accidents. The age range was 4 to 34 years for the motorcycle group and 1 to 65 years for the bicycle group. Males represented 70.7% of the motorcyclists and 59.8% of the bicyclists, while 29.3% of the motorcyclists and 40.2% of the bicyclists were female. The average age of the motorcyclist was 20.6 years with 20.9 years the male average and 19.8 years the female average (Fig 1). The average age of the bicyclist was 17.3 years with 17.7 years the male average and 16.9 years the female average (Fig 2).

Figure 3 shows the distribution of patients according to the month of the year for motorcyclists. The inclement months of December, January, and February in Wisconsin suppress the number during this period; however, with the arrival of warmer weather in May the numbers rapidly incease. A slight drop-off is noted in August during the break between the summer session and the fall term. A similar monthly pattern is seen with bicycle injuries (Fig 4).

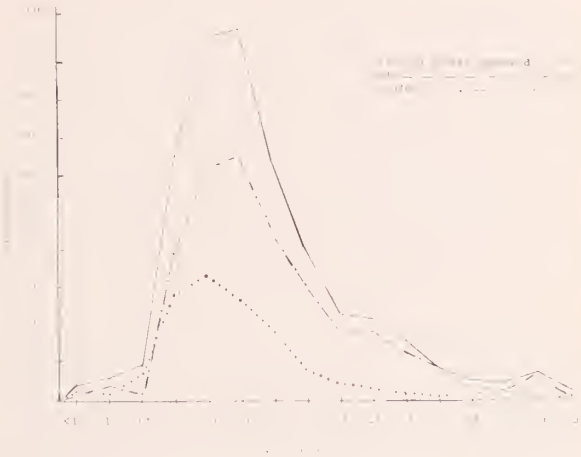

Fig. 1—Motorcycle-injured patients.

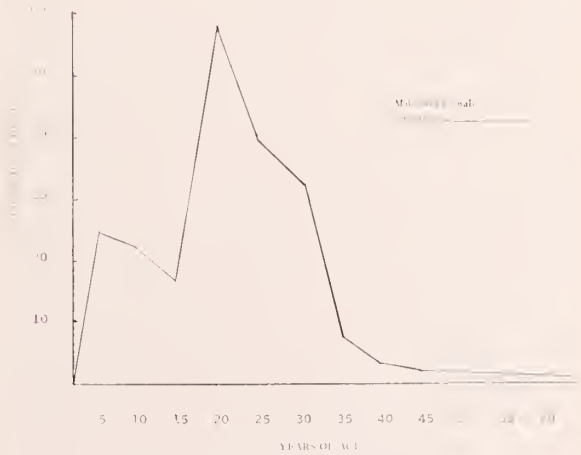

Fig. 2—Bicycle-injured patients.

Presented at the annual fall meeting of the Wisconsin Orthpedic Society, Oct. 20, 1967, Racine.

Doctor Pellegrino is a Resident in Orthopedics, University of Wisconsin Medical Center.

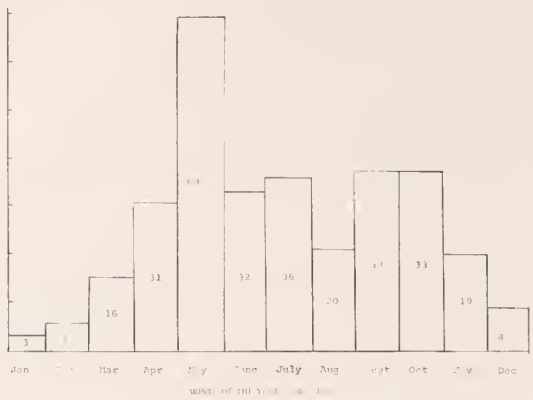

Fig. 3—Motorcycle-injured patients.

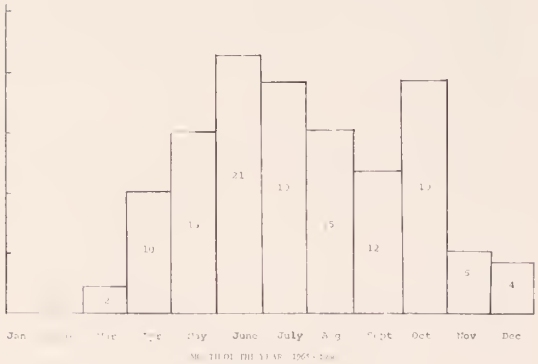

Fig. 4—Bicycle-injured patients.

The injuries were classified regionally into head injuries, trunk injuries and extremity injuries. The types of injuries were categorized into soft-tissue, osseous, and joint injuries for the regions involved. For both accident groups the extremity injury was the most common type as seen in 93.0% of the motorcyclists and 96.0% of the bicyclists. Table 1 depicts the pattern of injuries for both groups. A lower extremity injury was more frequent in the motorcyclists than in the bicyclists, but in both groups the lower extremity was injured more often than the upper extremity. There was a greater tendency for the motorcyclist to have both an upper and a lower extremity injured than the bicyclist. The extremity injuries were more apt to be on the right side for both the upper and the lower extremities for the motorcyclists, while the right side predominated only in the lower-extremity injuries for the bicycle group. In both accident groups the soft-tissue and joint type of injuries were most common in both the lower and the upper extremities (Table 2).

TABLE 1—*Extremity injuries from cycle accidents*

Pattern of Injuries	Motorcycle	Bicycle
I. Totals		
A. Total upper and lower limbs	569	195
B. Lower limbs	379 (66.6%)	108 (55.8%)
C. Upper limbs	190 (33.4%)	87 (44.2%)
D. Patients with both an upper and a lower limb or limbs injured	88 (20.0%)	25 (14.1%)
II. Lower Extremity		
A. Right lower limb	160 (42.2%)	50 (46.3%)
B. Left lower limb	123 (32.4%)	38 (35.2%)
C. Both lower limbs	96 (25.3%)	20 (18.5%)
III. Upper Extremity		
A. Right upper limb	87 (45.8%)	30 (34.5%)
B. Left upper limb	71 (37.4%)	27 (30.0%)
C. Both upper limbs	32 (16.8%)	30 (34.5%)

TABLE 2—*Lower extremity*

Types of Injuries	Motor-cycle	Bicycle
I. Soft-tissue (lacerations, abrasions, etc.)	46.1%	37.3%
A. Thigh	17	6
B. Leg	125	22
C. Foot	48	13
II. Osseous (open and closed)	7.8%	5.4%
A. Femur (1 open in motorcyclists)	5	0
B. Tibia-fibula (6 open in motorcyclists)	19	3
C. Patella	3	0
D. Tarsus to distal phalanx (1 open in motorcyclists)	5	3
III. Joints (sprain, dislocation, etc.)	46.1%	57.3%
A. Hip (1 Fx-dislocation in motorcyclist)	19	8
B. Knee	131	34
C. Ankle to D.I.P. joint	40	21

TABLE 3—*Upper extremity*

Types of Injuries	Motor-cycle	Bicycle
I. Soft-tissue	40.8%	45.4%
A. Upper arm	8	2
B. Forearm	31	8
C. Hand	48	34
II. Osseous (open and closed)	13.6%	8.2%
A. Scapula-clavicle-humerus*	5	2
B. Radius-ulna	6	4
C. Carpus to distal phalanx (15 closed and 3 open for motorcyclists)	18	2
III. Joints	45.6%	46.4%
A. Shoulder (3 glenohumeral for motorcyclists and one A-C separation for both)	29	11
B. Elbow	48	24
C. Wrist to D.I.P. joint (2 MCP thumb dislocations for motorcyclists)	20	10

*(4 clavicles and 1 scapula for motorcyclists and 2 clavicles for bicyclists)

In the lower extremities the soft-tissue injuries occurred most frequently in the lower leg (i.e., knee to ankle) and least commonly in the thigh (i.e., hip to knee) for both groups (Table 2). Fractures represented only 7.8% in the motorcycle group and 5.4% in the bicycle group. The motorcyclists' fractures were open in 28% in the lower extremity fractures in contrast to no

TABLE 4—*Head injuries*

Types	Motorcycle	Bicycle
I. Soft-tissue	58 (77.3%)	51 (78.4%)
II. Osseous	10 (13.3%)	6 (9.3%)
A. Teeth	6	4
B. Skull—facial	4	2
III. Intracranial	7 (9.3%)	8 (12.3%)

TABLE 4 (con't)—*Trunk injuries*

Types	Motorcycle	Bicycle
I. Chest (contusion, abrasion, rib fracture)	5 (13.9%)	1 (12.5%)
II. Abdomen (abdominal wall and visceral)	12 (33.3%)	2 (25.0%)
III. Spine and Pelvis (contusion, fracture, etc.)	19 (52.8%)	5 (62.5%)

open fractures in the bicycle group. Three-fourths of the open fractures involved the tibia and/or the fibula. The knee was the most frequently injured joint in the lower extremity of both groups; however, dislocations were rare.

Soft-tissue injuries in the upper extremities were seen most often in the hand in both groups (Table 3). Fractures occurred in 13.6% of the motorcycle group and 8.2% of the bicycle group with upper extremity injuries. Of the fractures in motorcyclists 10.3% were open while none of the fractures in the bicyclists was open. The bones of the hand were more commonly fractured in motorcyclists, whereas the radius and/or ulna fractures were more common in the bicyclists. Of the joints injured the elbow was most often injured in both groups, and dislocations occurred in 4.1% of the motorcyclists' joint injuries and 2.2% of the bicyclists' joint injuries.

Head injuries occurred in 75 of the motorcycle patients or 17% of the total injured, whereas 65 bicyclists or 36.7% of the total injured had head injuries. Although it was not ascertained whether the patient was wearing a helmet, the smaller percentage of head injuries in the motorcycle group could probably be accounted for by the fact that a motorcyclist is more apt to be wearing some form of head protection. Soft-tissue injuries were by far the most common type of head injury in both groups. The teeth were especially vulnerable in both groups and intracranial injuries were slightly more common in bicyclists. Ocular foreign body injuries occurred in 3 motorcyclists and no bicyclist (Table 4).

Injuries involving the trunk (i.e., chest, abdomen, spine, and pelvis) were the least common in the regions involved (Table 4). Chest injuries were the least common trunk injury and the spine and pelvis injuries the most common. It is interesting that the most severe injury in the motorcyclists was a trunk injury with hepatic and renal lacerations resulting in a long, complicated hospitalization terminating in septicemia and death. On the other hand, the most severe injury in the bicyclists was severe craniocerebral trauma resulting in the rapid demise of the patient.

Physicians treating significant numbers of motorcyclists have found an injury which is unique to the motorcyclist and found in 13% of those treated by us, and it has come to be called a "motorcycle burn" in our institution. It is simply a first or second degree burn about the size of a silver dollar, located on the medial aspect of the leg usually about three or four inches above the ankle and is frequently infected. It is caused by direct contact with the exhaust pipe. Of those patients with this lesion 70% were female, probably because of their tendency to wear less clothing at this level and the fact that they are usually passengers with their limbs in proximity with the exhaust pipe. For some indeterminant reason the lesions were more common on the left than the right in contrast to the usual localization for lower extremity injuries. Motorcycles frequently have two exhaust pipes and when there is only one it is usually on the right side.

Of those patients treated for cycle injuries 13.2% of the motorcyclists required hospitalization while only 7.3% of the bicyclists required hospitalization. The average length of hospitalization was 21.3 days for the motorcyclists and 4.4 days for the bicyclists. The range of duration of hospitalization was 1 to 180 days for motorcyclists and 1 to 26 days for the bicyclists. The residuals and complications of the injuries of the cyclists are summarized in Table 5. The majority of the complications were as a result of extremity injuries and the incidence of complications was 20.7% in the motorcyclists and 8.3% in the bicyclists who were hospitalized.

Repeaters or motorcyclists who were treated on two or more occasions for different cycle accidents numbered 17 or 3.9%;

whereas, there were only 2 bicyclists (1.1%) who were repeaters.

In the state of Wisconsin the registered motorcycles increased from 32,587 in 1965 to 48,649 in 1966.[1] During this same period the total number of motorcycle accidents increased from 1,933 to 2,822 and the fatalities increased from 37 to 52. In 1965 there were 37 motorcycle accident fatalities in the state of Wisconsin with 2 in Madison and in 1966 there were 52 motorcycle accident fatalities in the state, and 1 in Madison.

The problem of motorcycle accidents in the United States began to raise some concern in 1961 when there were 700 deaths resulting from these accidents.[2] However, they have increased alarmingly over the years and by 1964 there were 1,100 deaths. The number of registered motorcycles in the United States rose from approximately 600,000 to double that figure during the same period. Of the deaths, 90% were in males. Nearly half of those killed had collided with passenger cars, whereas a third of fatalities occurred with overturning, running off the road, and other non-collision accidents. One-third of the victims were under 16 years of age and one-fourth were between 16 and 20 years of age according to statistics compiled by the Metropolitan Life Insurance Company.[2]

In Europe the problem of motorcycle accidents dates back farther than in this country and is also mostly in males; so much so that from 1951 to 1960 the general death rate of the male 15–19 age group in England and Wales remained unchanged despite the advances in medical skill and knowledge.[3] The death rate for females in the same age group was 43% less and this difference was accounted for by the mortality from motorcycle accidents.[3] In Britain there were 1,743 deaths in 1960 in contrast to 700 deaths in the United States in 1961 from motorcycle accidents.[2, 3] A boy owning a motorcycle for four years from age 16 to 19 in Britain has an 8% possibility of being killed or seriously injured during this period.[4]

A study done at the University of Adelaide in South Australia from 1963 to 1964 pointed out that in bicycle (pedal cycle) accidents the majority of the accidents occurred because the cyclist turned in front of the car, whereas the majority of motorcycle accidents occurred when the motorcycle was going straight and the car was changing direction.[5] In this same study, the incidence of concussion and of skull fracture was the same for both those wearing and those not wearing helmets. The only difference between the two was that those wearing helmets did not receive any soft-tissue injury.[5] Helmets, however, have been shown to reduce the number of deaths by other authors.[6]

TABLE 5—*Residuals and complications of hospitalized patients*

A. Motorcycle patients
1. Thrombophlebitis, recurrent hip dislocation, chronic subluxation of hip.
2. Pneumonia
3. Receptive aphasia
4. Delayed union of tibia and fibula
5. Non-union of distal tibia
6. Non-union of tibia and fibula, chronic osteomyelitis
7. Thrombophlebitis
8. Bronchopneumonia, infarction of a kidney, hepatic abscesses, renal vein thrombosis, gastric ulcers, septicemia and death
9. Delayed union of femur
10. Wound infection
11. Nasolacrimal duct obstruction secondary to facial bone fracture, right hemiparesis
12. Flexion contracture of fifth finger

B. Bicycle patients—1 (8.3%)—Death from cerebral hematoma

A national study revealed that 20% of motorcycle accidents involved a driver on his first run and 70% involved a rented or borrowed cycle.[7] In most states all that is required to drive a motorcycle is an automobile driver's license. In October 1965 the state of New York enacted a law which requires a road test before a motorcycle operator's license can be obtained.[8] In many states it is legal for two cycles to ride abreast in a lane and they have as much right to be there as a car.[7] Motor vehicle departments and legislators across the country are trying to enact more safety measures such as requiring the use of helmets, special licenses and education for both the motorcyclist and the automobile driver. In Louisville, Ky., a six-hour course on motorcycle operation is given by the police department including three hours of didactic and three hours of field training.[8]

The study at the University of Wisconsin with regard to cycle accidents probably does not reflect the same distribution of minor-versus-serious injury as might be seen in certain lower socio-economic areas; however, the findings indicate that the vast majority of cycle injuries are ambulatory or minor injuries. There was only one death in the university motorcycle group (0.2%) in contrast to a 2.1% mortality rate per hundred injuries in the state. The study indicates the value of helmets as suggested by the fact that there are fewer head injuries in motorcyclists who are often seen wearing helmets

than the bicyclists who are seldom seen wearing helmets. The study also brings out the fact that in addition some protection should be afforded the extremities, especially the lower extremities where special guards can easily be applied to the front of the cycle similar to those used on most motor scooters. Changing the position of the exhaust pipe to directly under the rear fender and insulated from the back seat would also prevent motorcycle burns. There also may be wisdom in requiring bicyclists to wear helmets and emphasizing the fact that the bicycle is a safer mode of cycle transportation.

Summary

A study was made of 440 patients in motorcycle accidents and 177 patients in bicycle accidents with regard to age, sex, month of the year, area of injury, type of injury, and special injuries. A discussion of cycle injuries is presented and suggestions to help reduce them are made.

EDITOR'S NOTE: The Wisconsin Legislature recently passed a law which now requires a motorcyclist to wear a helmet.

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WISCONSIN'S HEALTH

by E. H. JORRIS, M.D., State Health Officer

ALCOHOL INVOLVED IN MOST DRIVER DEATHS

Alcohol was implicated in 66.8 percent of driver deaths in motor vehicle accidents during the first five months of 1968. This alarming fact was revealed by coroners' reports to the State Division of Health under a statutory reporting program which began shortly after the first of the year.

Of the 163 driver deaths where blood samples were taken and reported, 109 had some alcohol content in the blood. The point of intoxication set by law in Wisconsin is 0.15 percent by weight. Fifty-three—32.5 percent—of the driver fatalities were at or over the legal intoxication level according to the blood samples analyzed.

The reports do not reveal any particular age group where alcohol and driving seem to show the greatest problem. By age categories, the range went from zero to 100 percent alcohol involvement in driver deaths, but the number of deaths in these upper and lower ranges were too small to be statistically significant. Still it was particularly tragic to note that out of the 85 deaths reported among the youngest driver age group, 16 through 24, the reports show 55 as having some alcohol in the blood with 22 of these at or above the 0.15 intoxication level.

Women accounted for 20 of the vehicle driver deaths reported. Alcohol was indicated in eight women driver fatalities and four of these reports showed alcohol at or above the legal intoxication level.

The reporting law which went into effect in mid-January of this year, requires coroners to take a blood sample within 12 hours of the death of all motor vehicle drivers age 16 and over, who died within six hours of their accident. The blood samples are then sent for analysis to the State Laboratory of Hygiene. The results of the analyses are compiled by the Division for statistical and informational purposes. The statute directs the Division to make the statistical information available to the public, but does not permit the identification of individual drivers involved.

Wisconsin is one of 34 states where the 0.15 percent blood level is the legal point of intoxication. Five states set 0.10 percent as this level, and the remaining states have not set legal intoxication levels.

Therapeutic Dilemmas

No. 11 of a Series

Editor:

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COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

CHRONIC OBSTRUCTIVE LUNG DISEASE AND COR PULMONALE

Moderator: JOHN O. CHAMBERLAIN, M.D.
Participants: P. DAVID LEMPER, M.D.
DAVID M. GLASSNER, M.D.
HOWARD J. LEE, M.D.
ROBERT W. BYRNE, M.D.
GORDON SNIDER, M.D.
GUENTHER POHLMANN, M.D.

Dr. John O. Chamberlain: This morning we are concerned with the problem of cor pulmonale following long-standing pulmonary insufficiency. Doctor Lemper will present the case.

Dr. P. David Lemper (Resident in Medicine): This 134 lb, 51-year-old white man was admitted to this hospital from another city in March 1966 after his progressive edema and orthopnea had become recalcitrant to mercurial diuretics and phlebotomy. He was afebrile, had a pulse rate of 102 with regular rhythm, and the electrocardiograms suggested right atrial and ventricular hypertrophy. The blood pressure was 130/70 mm Hg. The liver was palpable three finger breadths below the costal margin, and there was clubbing of the fingers. He was cyanotic and polycythemic (hemoglobin 19.2 gm/100 ml; hematocrit 63%; white blood cell count 11,200/cu mm) and had a hypochloremic alkalosis (Na 140, K 3.7, Cl 86, Co_2 39.5, pH 7.51). The serum albumin-globulin ratio was 2.2–4.0. The predicted forced vital capacity (FVC) of 3.8 liters was observed to be 2.3 liters, and the predicted 70% ratio of forced expiratory volume in the first second to the forced vital capacity (FEV_1/FVC) was observed to be only 35% —alterations in pulmonary function thought to be indicative of combined obstructive and restrictive impairment.

The patient had been known to be asthmatic since early childhood and there was history of an asthmatic grandfather. Emphysema had been diagnosed at age 40.

Treatment during this admission included use of digitalis, diuretics, bronchodilators, corticosteroids and several phlebotomies. He gradually improved and was discharged with a reduction of hematocrit from 63% to 58% and a weight loss of 24 lb.

He was admitted again in April 1967 in a somnolent state with massive edema up to the abdominal wall. The liver was now down 5 finger breadths, he was cyanotic with neck veins filled from below; the breath sounds were distant, there was some wheezing, and a diastolic gallop rhythm. Again the electrolyte studies showed hypokalemia and carbon dioxide retention, but this time the pH was normal. The hemoglobin was 14.7 gm/100 ml; hematocrit 52%; white blood cell count 16,400/cu mm; and blood urea nitrogen (BUN) 10. Recovery from the congestive failure was slower than on the first admission. In addition to digitalis and diuretics, nasal cannula oxygen was used at a rate of 1 to 2 liters per minute. He was discharged on 0.25 mg of digoxin and 500 mg of acetazolamide (Diamox) twice daily after a weight loss of 18 lb in the 21 days of hospitalization. No corticosteroids had been used during this admission, but potassium gluconate, furosemide (Lasix), spironolactone (Aldactone-A) and bronchodilators had been employed.

Dr. Chamberlain: Doctor Glassner, since this is your patient, have you anything to add?

Dr. David M. Glassner: Doctor Lee has seen the patient intermittently since 1956, but I have cared for him only during the last two years. He had primarily seasonal atopic asthma until the age of 13. At this time he had pneumonia, after which the asthma became perennial. The next year he moved from the farm into a nearby city, without effect upon his condition. This man has a somewhat bizarre personality in addition to his severe pulmonary malady; in fact, when he came into my practice I felt that he behaved like an alcoholic, but I could never find substantial evidence of drinking. He smoked quite heavily despite being instructed not to do so, and it was never possible to maintain satisfactory contact with him in the periods between the severe cardiac breakdowns. It

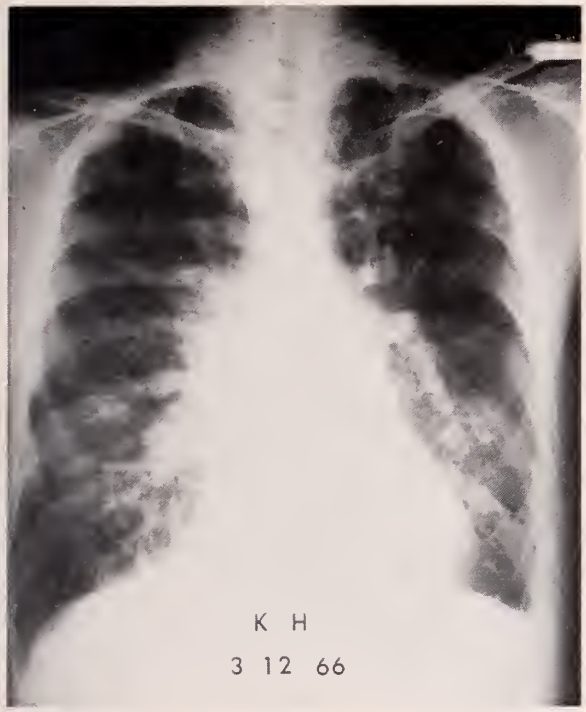

Figure 1

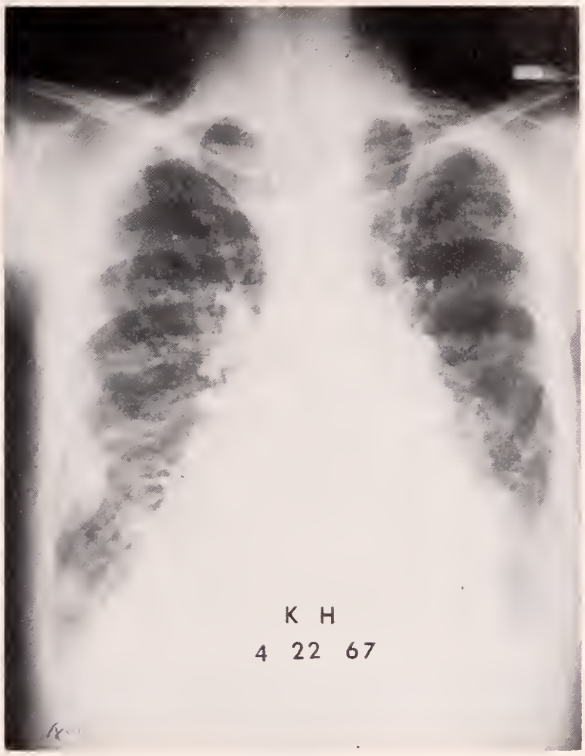

Figure 2

appeared that, although diuretic and other measures were being employed during these times, his local doctor was never able to get him to stay in bed for any lengthy period. It is almost certain that all dietary advice was disregarded. Perhaps Doctor Lee has something to add?

Dr. Howard J. Lee: The patient was always going to come in "next month," but never did so except when in extremis because of the obligations that business and family imposed upon him. Not mentioned in the protocol is the fact that he was unconscious for several days following skull fracture in an automobile accident in 1958, an episode that appeared definitely to potentiate the rigidity of his personality. I consider it also of great importance in the story to recognize the man's addiction to the bronchodilator spray. He would not discontinue this compulsive self-medication despite many attempts to convince him that he was increasing his difficulties through this practice.

Dr. Chamberlain: Doctor Byrne, would you please demonstrate the x-ray films?

Dr. Robert W. Byrne (Department of Roentgenology) : We have two sets of films. On the March 1966 admission we found a small heart (Fig 1) with little more unusual about it than a slightly elevated apex. The bronchopulmonary markings were accentuated except for a little paucity of lung markings in the left intraclavicular area. There was slight blunting of the costophrenic angle and a very small amount of pleural fluid on the left. Knowing nothing of the history of the case, I think that one would simply call this a "battle-scarred" lung; in spite of the linear peribronchial infiltrative changes it does appear a little too highly aerated. On the second admission, a year later, we found the heart considerably enlarged and the apex somewhat more elevated (Fig 2). The unusual vascularity and peribronchial changes in lung remained, and there was a little more fluid on the left; but the striking thing was the little pleural nodular effect that had appeared in both lungs laterally (Fig 3) and that cleared considerably in about six days. Figure 4 is a lateral view of the chest.

Dr. Chamberlain: Thank you, Doctor Byrne. Doctor Gordon Snider, who has had a great deal of experience in chronic obstructive pulmonary disease, is Professor of Medicine at Marquette School of Medicine and Chief of the Chest Service at the Wood Veterans Administration Hospital. He has kindly come in to discuss our case with us this morning.

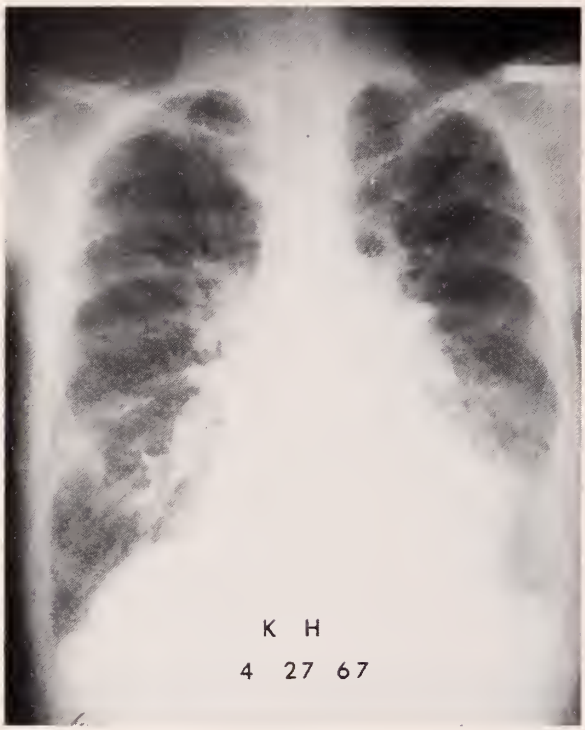

Figure 3

Figure 4

Dr. Gordon Snider: Certainly the most important thing to determine in such a case as the one before us is the nature of the man's heart disease. There is no history of any episode indicative of myocardial infarction or of an acute illness that might presage a myocardiopathy; and he is not hypertensive or alcoholic and does not have valvular disease. It is difficult to identify a primary cardiac disorder here. On the other hand, there *is* ample evidence of long-standing pulmonary disease, and it therefore becomes necessary to determine the intrinsic nature of that pulmonary disease in order to assess the likelihood of the heart ailment having arisen secondarily to it. The history is not characteristic of uncomplicated chronic asthma, and the response to bronchodilators has not been dramatic. But there is definite evidence of marked obstruction. The nodulation and diffusely accentuated bronchovascular pattern revealed in the chest roentgenograms suggests a small but unimportant amount of restriction. I suspect that measurement of this man's total lung capacity would reveal a value at the lower limit of normal or slightly below it. There is very little indication of attenuation of vascular shadows and no evidence of bullae to suggest destructive emphysema. And yet we have evidence of some air trapping, some overdistention, because the amount of air between the anterior border of the ascending aorta and the posterior aspect of the sternum is increased, as shown in the lateral film (Fig 4).

Some observers would say that this man has asthma and complicating chronic bronchitis. I prefer to label him simply chronic obstructive lung disease (COLD). It is important to distinguish between the several types of COLD: the predominant bronchitis or "blue bloater" (BB) type, the predominant emphysematous or "pink puffer" (PP) type, and the commonest group, the mixed type.

In the BB group, into which I believe our patient falls, cough and production of sputum, both dating from early years, are common findings. Cyanosis and polycythemia, particularly as the patient advances into the middle forties, are prominent, and it is not unusual for these people to have several bouts of congestive heart failure. Spirometry shows evidence of airway obstruction; lung volume measurements disclose a total lung capacity which is at the lower limit of normal or even slightly decreased and residual lung volume and functional residual capacity which are enlarged

but not nearly as much as in the pure emphysematous type. The BB type of patient has chronic hypercapnia, even in remission, and has more severe hypoxemia than the PP type. This is the reason for the cyanosis and polycythemia that characterizes the BB group. Diffusing capacity measurements are relatively well preserved. Our patient has lost considerable *gross* weight under treatment, but I doubt that there has been much loss in *dry* weight. It is characteristic of this group not to have much dry weight loss. Our patient, then, does not lose dry weight, he tends to be hypoxemic, cyanotic and polycythemic; he has relatively small lungs; and he becomes edematous in his bouts of heart failure. He is the "blue bloater."

The airway obstruction of the pure emphysematous type of COLD cannot be distinguished from that of the chronic bronchitic type by ventilatory function studies. But the emphysematous patient often has a total lung capacity that is 30% larger than predicted normal. His lungs are large, and although his vital capacity may be diminished, it is decreased only because the residual volume is tremendously increased. Polycythemia and cyanosis are rare, and arterial carbon dioxide levels are generally normal except in exacerbations. Hypoxemia is much less severe than in the BB type. The diffusing capacity is more diminished in the PP than in the BB patient. Because of his very large lungs the emphysematous patient has a much lower diaphragm than our present patient; it is virtually inverted. There is often a pronounced barrel-chest with a much greater AP diameter than we have seen in the lateral film of our patient. And in contradistinction to the cardiomegaly of the BB patient we often see a tear-drop heart in the emphysematous patient. He often has very prominent central vascular shadows but a marked paucity of vascular markings peripherally with markedly hyperlucent pulmonary lung fields. Furthermore, the PP patient frequently goes through his entire course to death without manifest heart failure, or has heart failure only in the terminal episode. Dyspnea is his major complaint, and he uses his accessory respiratory muscles a great deal of the time. This patient's disease is ushered in by the complaint of shortness of breath; cough and expectoration are relatively minor symptoms. Severe dry weight loss is frequently a part of the picture. This patient is constantly fighting for breath, he does not become cyanotic, and he loses weight rather than developing bouts of heart failure and becoming swollen. He is the "pink puffer."

On the basis of present evidence I feel, therefore, that our patient has cor pulmonale secondary to chronic obstructive lung disease of the BB, or chronic bronchitic, type.

Dr. Chamberlain: Doctor Glassner, would you care to say anything about asthma in relation to this malady?

Dr. Glassner: In allergy practice we see two types of asthmatic patients that worry us. One is the individual who develops the disease in adult life; these cases tend to progress and are very difficult to handle. The other is the child who has had life-long asthma that does not improve under good management as he enters adolescence. This is the type of our present patient. He became progressively worse as he advanced in adult life until he presented the chronic picture that Doctor Snider has described. Not completely, however, for profuse production of sputum has not characterized his state, at least not latterly.

Dr. Snider: We have seen a number of patients in the chronic bronchitis group who come in with chests that sound like music boxes, who have very low FEV_1's as this man did, and who have hypercapnia and hypoxemia and yet do not cough or raise sputum until they begin to improve. But apparently that did not happen with the present patient.

A Physician: What part does cigarette smoking play in the purely asthmatic patient?

Dr. Glassner: I cannot answer that categorically, but at least I can say that for the young individual, the 16- or 18-year-old, smoking usually presents no complicating problem because these individuals quickly learn that it increases their coughing and wheezing and greatly limits their activities.

A Physician: What about its role in the type of case we are considering here today?

Dr. Guenther Pohlmann: We have had several patients come through the pulmonary function laboratory here in this hospital, who positively had no history of cigarette smoking and yet had chronic obstructive lung disease of the pink puffer type with a one-second respiratory flow rate of 35%. But it appears that in the other type, the blue

bloater, there must be either heavy smoking or recurrent infectious or allergic airway disease to set up the picture.

Dr. Snider: I am sure that 95% of the people I see with this disease have a history of heavy cigarette smoking for 20 years or more. Such a patient as the one we are discussing today, whose history goes back to early childhood, could conceivably have developed the malady without smoking, but this has been a rarity in my experience. I think that possibly the relationship of smoking to the PP, or pure emphysematous, type is not so firmly established.

Dr. Chamberlain: What would you say, Doctor Snider, about management in such a patient as the present one, a man with the chronic bronchitic or blue bloater type of obstructive lung disease?

Dr. Snider: It is essential to recognize that the circulatory symptomatology is merely a reflection of the pulmonary disease and that first attention must be directed toward the latter. The patient is cyanotic, and we know without blood gas studies that he is hypoxemic and requires oxygen administration. But it is not necessary to use high concentrations of oxygen, and to do so might be dangerous. All that is required is to raise the arterial PO_2 into the range of 60 to 80 mm Hg and give him a saturation in the low 90s. A nasal cannula with a flow of 1 to 3 liters per minute will provide an oxygen concentration in the inspired air in the range of 24% to 30%. An oxygen concentration of 30% will increase the inspired partial pressure by 50%, from 150 mm Hg to 225 mm Hg. This will be enough to produce a near normal partial pressure of oxygen in most of the underventilated alveoli and to provide an adequate concentration of oxygen in arterial blood. The amount of oxygen carried to the tissues will also depend on circulatory factors.

Whenever oxygen is administered to a patient who is or may be hypercapnic we must determine whether correction of the oxygen lack is removing hypoxemic ventilatory drive, decreasing the patient's total ventilation and worsening his hypercapnia. Measurement of tidal volume, respiratory frequency, and minute ventilation may provide a rough guide, but determination of the arterial partial pressure of CO_2 ($PaCO_2$) is the best index to follow. If alveolar ventilation is down, $PaCO_2$ goes up; if $PaCO_2$ is down, alveolar ventilation must be up. Oxygen should be administered continuously at low concentration and not intermittently at high concentration. Intermittent high concentration depresses ventilation and raises the carbon dioxide level; then when treatment is stopped, the oxygen in blood and tissues is quickly exhausted because it is not stored; the carbon dioxide, which *is* stored, comes out into the alveoli and the patient's alveolar oxygen tension falls to an extremely low level—to the level, indeed, at which cerebral dysfunction, cardiac arrhythmias and cardiac arrest are distinct possibilities.

Simultaneously with administration of oxygen, other measures need to be taken to increase alveolar ventilation and promote bronchial secretion and drainage, such as hydration, administration of aminophylline intravenously and antibiotics to control infection. Diuresis and phlebotomy are used for edema and polycythemia.

The inhalation of aqueous mists is one of the best ways of thinning bronchial secretions. Aerosol therapy with normal saline or 3% propylene glycol may be administered continuously, either heated or cold using a mechanical or ultrasonic aerosol generator and a face mask. Bronchodilator aerosols (e.g., isoproterenol or racemic epinephrine) may be given intermittently for 15 minutes at one- to three-hour intervals using a hand held pressure nebulizer or intermittent positive pressure breathing (IPPB) machine. It should be remembered that when IPPB is being used intermittently in this way, its purpose is effective delivery of aerosol therapy, not hyperventilation and the elimination of carbon dioxide. The patient should be encouraged to cough, and postural drainage with chest wall clapping and vibration are often useful measures in promoting mobilization of bronchial secretions.

When these measures are not effective in improving alveolar ventilation, assisted or even controlled ventilation may be necessary to eliminate CO_2 while oxygenating the patient. We prefer to insert a cuffed oro or nasotracheal tube and to ventilate continuously with one of several pressure or volume cycled IPPB machines. Endotracheal tubes can be left in for many days if they are properly humidified. Tracheostomy is rarely necessary and this operation should be done electively with an endotracheal tube in place.

A Physician: Can you worsen cor pulmonale through use of positive pressure ventilation?

Dr. Snider: Yes, you can. A small but significant number of patients will have their work of breathing increased by intermittent positive pressure. They are unlikely to become hypoxemic because oxygen is usually delivered at 40% or higher concentration, but their alveolar ventilation will actually be decreased. I do not know how to identify such patients except to say that they dislike the equipment, "fight" the machine, and do not do well clinically. In recent weeks we have shown a rise in arterial $PaCO_2$ in a few such patients before and after 15 minutes of intermittent positive pressure breathing.

A Physician: Can you precipitate so-called forward failure because of decreased cardiac output when using assisted ventilation in a patient with cor pulmonale?

Dr. Snider: This does happen sometimes, particularly in a patient who has been hypoxemic. There is a fall in cardiac output because of decreased venous return due to increased intrathoracic pressure with IPPB. This fall in venous return is transient in the normal individual because peripheral venous pressure is increased by a reflex increase in peripheral venomotor tone, thus restoring the pressure gradient between the periphery and the heart. But the patient with obstructive lung disease may be unable to increase his peripheral venous tone, and occasionally there may be a persistent decrease in venous return and cardiac output and a fall in systemic arterial blood pressure.

A Physician: Do you agree with the statement sometimes made that digitalis is contraindicated in the patient with chronic obstructive lung disease?

Dr. Snider: I do not believe that harm is done by digitalizing the COLD patient with complicating heart failure unless this is done in the presence of hypokalemia or hypoxemia with development of a serious arrhythmia. However, in our own practice we are tending increasingly not to rush into use of digitalis but to leave its introduction to the second or even the third day after determining what can be accomplished through diuresis, the relief of hypoxemia, and promotion of bronchial drainage.

Dr. Chamberlain (summarizing): Thank you, Doctor Snider and all others who have participated. This morning we have been engaged with the subject of chronic obstructive pulmonary disease and complicating cor pulmonale. Particular attention has been paid to the distinguishing features of the two principal types of the malady and the therapeutic measures especially useful in each.

PIGEON BREEDERS' DISEASE: A CLINICAL STUDY OF A HYPERSENSITIVITY PNEUMONITIS

JORDAN N. FINK, MD, JOSEPH J. BARBORIACK, PhD, ABE J. SOSMAN, MD, and DONALD P. SCHLUETER, MD, Marquette School of Medicine, Milwaukee, Wis.: *Ann Intern Med* 68:1205–1219 (June) 1968

Increasing number of reports indicate that individuals engaged in occupations associated with exposure to organic dusts may develop an interstitial pneumonitis. The onset of symptoms four to six hours after exposure, and the presence of high titers of precipitating antibody against the suspected agents suggests that a hypersensitivity reaction plays a role in the genesis of the disease. Over the past several years we have observed such an illness in 12 individuals working with pigeons. All patients developed symptoms of chills, fever, dyspnea, and malaise within a few hours after exposure to pigeons. These symptoms subsided within 12 to 18 hours, reoccurred on repeated exposure.

Examination during the acute attack revealed end-inspiratory crepitant rales associated with dyspnea and leukocytosis. Chest roentgenograms revealed a diffuse interstitial process in most patients. Pulmonary function studies revealed restriction and a diffusion defect and at times obstruction. Histologic examination of lung tissues indicated that this process was a granulomatous interstitial pneumonitis. All patients had high titers of precipitating antibody against various pigeon materials. Intradermal injection of these materials resulted in erythema and induration maximal by four hours consistent with an Arthus type of reaction.

In most of these patients, avoidance of contact with pigeons was associated with reversal of the clinical and immunologic abnormalities. When the exposure to pigeons was prolonged and severe, however, disabling obstructive respiratory impairment ensued which could not be reversed by either avoidance or corticosteroids.

These studies indicate that the presence of a hypersensitivity pneumonitis should be considered in individuals working with pigeons and presenting with respiratory and systemic symptoms.

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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Rh Immunoglobulin and Its Use in Preventing Erythroblastosis

By DANIEL F. JOHNSON, M.D.
and ALFRED L. KENNAN, M.D.
Madison, Wisconsin

■ THE OBSERVATION BY Theobold Smith in 1909, that in the presence of passive antibody the corresponding antigen will not immunize has been confirmed. From the many reports there emerged the new immunological principle that passive immunity strongly suppresses active immunity. A specific practical use of this principle has now been developed and hemolytic disease in the fetus due to the Rh factor can now be prevented by passive immunization immediately after delivery, i.e., within 72 hours. This protects the mother from the stimulus of any antigen (fetal red cells) which may be infused into the mother at delivery. This is the usual time for any substantial dose of antigen to get into the mother. Obstetrical accidents (placental separation) in Rh negative women are also a time when large numbers of fetal cells are transfused and this is also an important time to passively immunize. All of the fetal sequelae resulting from maternal sensitization can now be prevented by protecting the mother against this sensitization.

In a clinical trial the high titer anti-D globulin has been virtually 100 percent effective. In 1199 women who received this material after delivery, one became sensitized. By contrast, of 731 who were not so treated, 52 became sensitized.

Important Points

1. It should never be given to any Rh positive patient.
2. It can never be given before delivery.
3. It should only be given when the mother delivers an Rh positive baby.
4. It can never be given when the mother has antibodies, for once she is sensitized, it will not reverse this.
5. It has to be given with each pregnancy in which there is a positive child.
6. It is specific only for the D antigen which is the most prevalent cause of hemolytic disease.
7. It should be used after abortion if this occurs after the 10th week of pregnancy.

The procedure to be followed is first to know all the Rh negative patients in your obstetric practice. At appropriate intervals before delivery, a screening test for antibodies should be done. At delivery, a sample of the mother's blood and cord blood should be taken for an antibody determination and the Rh of the child. If the mother and the child do not have antibodies and the child is Rh positive, the mother should receive the immunoglobulin. This is currently available as RhoGam from the Ortho Company. It is packaged in a 300 mcg dose which is in a sterile vial with accompanying materials for crossmatching. This is the dose that has been found most effective and larger or smaller doses should not be given. The crossmatching procedure should be scrupulously followed before using this drug.

From the Department of Gynecology and Obstetrics, University of Wisconsin Medical School.

Doctor Johnson is a Resident in Gynecology and Obstetrics.

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W. D. James, M.D.

PRESIDENT'S PAGE

Education Is Key to Health Quackery Menace

THE EDITORS OF THE Wisconsin State Chamber of Commerce monthly bulletin, FORWARD, asked me to prepare a column for their July issue. I was especially pleased to respond in light of the Chamber's energetic program against health quackery. I'd like to share my thoughts with physicians as well as businessmen:

"Recent sociology studies indicate that nearly 250,000 persons in the U.S. (or about 5,000 Wisconsin persons) might not die this year if non-college educated persons had the same death rate as the college-educated population. Even if the sociologists have exaggerated their conclusions, it is a dramatic fact that lower rates of death from most causes have a direct correlation with higher educational attainment.

"Put another way, it means that illness, injury and death for thousands of Wisconsinites each year could be prevented or minimized if we—doctors and patients—would but apply what is already known about good health and safety.

"Health quackery is cruel in its falsehood, costly in dollars and often criminally preys upon the desperate hopes of the credulous sick. It must be fought with stern and unrelenting pressure. The key is education. The State Medical Society is pleased that the Wisconsin State Chamber of Commerce is bringing this problem to the attention of business and industry and suggesting methods by which we can jointly fight its menace.

"We also believe that education is the single most important tool to help the people of Wisconsin to better health and safer living. We, as doctors, know, for example, that immunizations prevent tetanus, polio and measles and many other dangerous conditions. Yet, thousands of our citizens do not have this protection. We know that the Pap smear can discover early uterine cancer at a time when it can still be cured. Yet, many women are not moved to get this simple test. We know that seat belts can save countless lives and untold suffering. Yet, most people won't use them. The list is almost endless . . . yet, so few take advantage of what science and common sense dictate.

"The President of the American Medical Association said recently: 'People are basically interested in their bodies and what can go wrong with them. If more attention is devoted to preventive medicine through programs to inform and motivate the average citizen, more benefit will be derived than through all the federal health care systems we could devise.'

"Business, government, medicine, and the public have made great progress in the field of industrial health and safety. There is no reason why, working together in health education we cannot have equal or greater success in all areas of health to the everlasting benefit of the people of Wisconsin."

W. D. James MD

the WISCONSIN MEDICAL JOURNAL
Published Monthly

SEPTEMBER 1968

Vol. 67 No. 9

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

The Case for PACE

■ POLITICS IN A FREE SOCIETY, such as ours, seems to have a special attraction for clowns, buffoons, the inept, the self-seeking, the well-intentioned louts, and the outright crooks. Happily, it also draws serious, conscientious men of great capability and high morality. The task of the elector to choose the best man for an elective position is frequently complicated by spurious issues or by unfamiliarity with the real issues involved.

As our society grows immensely more complicated and the interconnection of politics with economics and social problems becomes more intimate, the better educated elements of the community bear a heavier burden than ever to inform the rest of the community about the real significance of the issues in an election.

In recognition of this responsibility, a group of Wisconsin professional people, consisting of doctors, dentists, lawyers, engineers, educators, and others, have formed a group known as Professional Association for Civic Education (PACE). It describes itself as "an independent, voluntary, non-profit, unincorporated association of individual professional persons and others . . . not affiliated with any political party."

Its purposes are "to provide education for professional persons and others in the proper exercise of civic responsibility for the improvement of government and to encourage professional persons and others to take a more active role in government affairs . . ."

While generally similar in purpose and function, PACE is independent of AMPAC, the American Medical Political Action Committee. By special arrangement, however, membership in PACE provides automatic membership in AMPAC. PACE has been endorsed by the House of Delegates of the State Medical Society of Wisconsin, which encourages doctors to become members on an individual, voluntary basis.

Under the law, a professional society may contribute to the educational programs of such organizations as PACE in the area of public affairs.

PACE's *civic education* provides authoritative, bipartisan legislative bulletins, practical technical information concerning politics for professional people, advice on how to be effective in government affairs, as well as thoughtful analysis of voting records and political activity.

Individual membership dues for PACE are used for *political action*—to support candidates and office-holders who deserve election or reelection to government office. In this context, PACE is the political expression of the influence and stature doctors and other professional people have in their community. It is through the instrumentality of the or-

ganizational structure offered by PACE that we can make effective the power that accrues to us by virtue of our position in the community.

Because PACE is bipartisan, political support is given on the basis of merit; contributions are made after a searching analysis of the issues at the local level. In this way, we, as the professional elements of our communities, can discourage some of the hang nails on the hands of political progress in our city, town, county, and state governments.

If we have ever complained about the mis-use of our tax money, if we have deplored the clunks and boors on the political scene, we ought to do something about the matter now. We ought to support PACE both through local political activity and with individual membership contributions.

If we are serious about civic responsibility, we must join PACE now. For membership information, write to Professional Association for Civic Education, 144 West Madison Street, Waterloo, Wisconsin, 53594.—DNG

A Statement of the Current Status of Normal (Whole, Pooled) Human Plasma

This statement has been prepared at the request of the Division on Maternal and Child Welfare of The State Medical Society of Wisconsin to clarify the status of pooled normal human plasma as a therapeutic agent. During the last four months a series of actions have occurred which has resulted in the condemnation of pooled human plasma.

Chronologically these actions began with a manuscript published in the March–April issue of *Transfusion* entitled, "A Controlled Study of the Safety of Pooled Plasma Stored in the Liquid State at 30°–32° C. for Six Months", by A. G. Redeker, C. Hopkins, B. Jackson, and P. Peck. The National Research Council Committee on Plasma and Plasma Substitutes (NRC) reviewed the manuscript, previous to publication, and on the basis of this study, issued a memorandum for publication in the March–April issue of *Transfusion* and a press release for April 5, 1968. This statement, based on the findings of the Redeker paper, which demonstrated a 10% incidence of hepatitis in recipients of pooled plasma, concluded that the use of pooled plasma should be "discouraged and even discontinued". The statement pointed out that a safe substitute was available in the form of serum albumin, and that there was no evidence that pooled plasma had any unique advantages over albumin.

The Redeker study was a prospective study in which recipients of pooled plasma and a control group treated with albumin were studied following treatment with these biologicals by careful, repeated physical examinations, and by liver function tests. There were no cases of hepatitis in patients treated with albumin, whereas, 10% of the patients receiving pooled human plasma developed hepatitis.

The Division of Biologics Standards of the National Institutes of Health (DBS), acting on the data in the Redeker manuscript, and on the statement issued by the NRC, phoned all holders of licenses for pooled plasma the day before the general press release to alert them to its appearance and asked the licensees to voluntarily relinquish their licenses. On May 20, 1968, the DBS issued a memorandum to all holders of a license for normal human plasma notifying them that they were "not to sell or ship this product in interstate or foreign commerce after June 15, 1968", and that "steps will be taken on June 15, 1968, to revoke without prejudice all presently issued licenses."

Three easily identifiable problems have been created by the actions of the National Research Council and the Division of Biologics Standards. First, it is not evident that sufficient supplies of plasma substitutes, such as albumin, are available to fulfill the requirements not being met through the use of pooled liquid plasma. Secondly, there is some uncertainty as to whether albumin is completely equivalent to pooled liquid plasma. Immunoglobulins IgA and IgM are available in plasma but are not available in albumin or in Cohn fraction 2, which would provide IgG immunoglobulin. Finally, unless blood banks can rapidly develop means to convert their outdated plasma into acceptable fractions, their ability to utilize effectively the blood supply available to them will be seriously impaired. Expansion of component therapy, which is necessary for the conservation of blood resources, may be restricted, and the commercial availability of plasma protein fractions and their inclusion as benefits in many medical insurance plans may jeopardize donor recruitment.

Unfortunately, at the present time it appears that, in view of these developments, it would be unwise to continue to use pooled human plasma. Confirmation or challenge of the results in the Redeker et al study will entail carrying out a similar study which is unlikely because of the official action that has been taken (DBS and NRC), and because of the time, effort, and financial support that will be required to repeat these studies. Unless overriding considerations exist, the use of liquid pooled, whole plasma can no longer be recommended.—S. P. Masouredis, M.D., *Executive Director*, Milwaukee Blood Center, Inc., 763 North 18th Street, Milwaukee, Wis. 53233

Medical-School Dean Checks Up on Country Doctors

EDITOR'S NOTE: This newspaper article, reprinted below, represents a good idea. Perhaps more schools should consider such a program.

The July 18, 1968, issue of Medical Tribune featured a similar situation in Seattle, Wash., when Dr. John R. Hogness, Dean of the University of Washington School of Medicine, spent two weeks in Omak, Wash., a lumbering, apple orchard, and grain-growing town, on a research project that was to have been a secret until his return, although the news leaked out. His conclusion: well-trained general practitioners fill a very definite need and fill it well in rural areas.

GREENVILLE—Muhlenberg County has 10 doctors, one hospital, and a medical-school dean.

It is losing the dean today, but hopes to pick up another one later in the fall, plus a commissioner of health.

All this week, Dr. Donn L. Smith, dean of the University of Louisville School of Medicine, has been in the county, observing how its 10 doctors provide medical care in a rural setting.

It will help him determine how well his school is preparing students for the problems of rural medicine, an area that tends to be neglected these days.

The county medical society has tendered similar invitations to Dr. William Willard, vice-president of the University of Kentucky Medical Center, and Dr. Russell E. Teague, state commissioner of health.

Both have expressed interest, if their schedules can be worked out.

The novel idea of inviting the top medical administrators to the state for "a week in the country" belongs to Dr. George Brockman, a Greenville internist who is president of the Kentucky Medical Association.

"It occurred to us," says Brockman, "that we go up to Louisville, Frankfort, and Lexington for medical meetings and talks, and have a good idea of how they do things.

"But they don't get down to us, to know our problems. I know all three of these fellows, so I invited them."

Smith Says He Gains Most

Smith's willingness to devote an entire week of his busy schedule to this project emphasizes his belief that one needs to climb down occasionally from "the ivory tower" of a medical center.

"I'm the gainer from all this," he asserts. "I'm learning six times as much as I can tell these doctors.

"For example, I'm seeing for the first time the impact of medicare on the normal practice of medicine."

"I'm impressed at what these doctors can do, and how they go about it," Smith adds. "And I'm a bit frightened at what my graduates are expected to do—every day, all day long."

But the week's tour, Smith figures, should help him answer questions from his students "on what it's like in the great, outside world."

10 Doctors for 30,000 Residents

In Muhlenberg County in West Kentucky, the 10 doctors must treat about 30,000 persons, an average of 3,000 persons per doctor. The national ratio is one physician for every 1,000 persons.

There's one hospital, the 72-bed Muhlenberg Community Hospital, that is getting more extended-care facilities. Mining is the big industry.

The area is about equidistant from medical schools in Louisville and Nashville, Tenn. The physicians do longdistance consulting with specialists in both cities. They also consult specialists in Owensboro and Hopkinsville, both about 30 miles away.

Each day during his visit Smith accompanies a couple of doctors as they treat their normal run of patients.

One day he went to Central City to watch a couple of general practitioners. Thursday he visited the county's three surgeons, who practice together in Greenville. These are the county's two largest communities. Before departing today, he was to talk at the high school in Greenville on careers in medicine.

And each day he fields questions that reflect the special problems of rural medicine.

What postgraduate courses does the U of L have now?

What medical topics will be offered on the educational television system being developed in Kentucky?

How do you attract young physicians to small towns?

Is group practice the answer to many problems?

And, inevitably, something like, Do you know a good urologist you can send us?

But Smith also is seeing the advantages of rural practice.

Small Town Has Advantages

A young surgeon, Dr. Robert E. Robbins, told Smith he "couldn't be happier" about choosing a small town rather than his native Lexington to begin a career.

Robbins recalls how he was plunged into a variety of surgical procedures within two weeks after his arrival in Greenville. In a large city, it would have taken him a couple of years to build a practice.

On this point Smith agrees. "Coming off that residency, when things are still fresh, is the prime time to get in up to your neck."

By tonight the 10 doctors in Muhlenberg County will be back to normal, with too many patients and not enough help. But, till then, "they're getting a big kick out of having their own medical-school dean," says Brockman.—Reprinted from *The Louisville Times*, Oct. 13, 1967, by staff writer Wayne Welch.

The following message to physicians regarding care furnished ECF patients was mailed directly to physicians by the Social Security Administration. The intent of the message is to define concepts crucial to an understanding of the level of ECF care which is covered by the law. WPS is reprinting this message at the request of the Social Security Administration.

WHEN CARE FURNISHED TO ECF PATIENTS CAN BE COVERED BY MEDICARE

To assure prompt and equitable determinations as to whether care furnished to patients in extended care facilities is covered and can be paid for under Medicare, the understanding and cooperation of physicians, hospitals, ECF's, utilization review committees, intermediaries, and carriers are vital. We hope this message will help to achieve these objectives.

A. **WHAT IS "EXTENDED CARE"?** The covered level of care provided when the patient's condition upon his discharge from a hospital requires him to be in an institution for the *primary* purpose of receiving continuous skilled nursing services and other professional services.

B. **WHAT ARE "SKILLED SERVICES"?** A skilled service is one which *must* be furnished by or under the supervision of trained medical or paramedical personnel. A service is not skilled merely because it is performed by a trained medical or paramedical person. A service which can be safely and adequately self-administered or performed by the average, non-medical person, without the direct supervision of trained medical or paramedical personnel, is a non-skilled service without regard to who actually provides the service.

C. **WHAT IS "NONCOVERED CARE"?** *Any* level of care less intensive than extended care. Formerly, all noncovered care was referred to as "custodial care."

D. **WHAT ARE THE RESPONSIBILITIES OF THE ATTENDING PHYSICIAN AND HOSPITAL?** The attending physician customarily plans in advance for the needs of his patient including, where appropriate, transfer from a hospital into an extended care facility. The hospital can and should aid in this planning process. Following is the preferred approach:

1. While the patient is in the hospital, a medical information summary should be prepared including the physician's order for the patient's care in the facility, a profile of the patient's condition, and the services expected to be needed.
2. This summary should be submitted by the hospital to the facility prior to the time of the transfer of the patient.
3. If the summary is to be incorporated into a form, it may be incorporated into a standard form agreed to by the intermediary and the providers of service.

When this information has not been submitted in advance as indicated above, alternate approaches should be used to supply the needed information. We have been advised by the medical profession that good patient care requires the extended care facility to have available by the time of admission, in writing, the required patient care information. The written data may in some instances be preceded by telephone orders which would make possible advance preparations for care.

(continued next page)

E. WHAT PROCEDURES SHOULD EXTENDED CARE FACILITIES FOLLOW?

If adequate information is received, requiring it to furnish skilled services which are obviously covered care, no special action need be taken by the ECF. However, if the ECF thinks there could be reasonable doubt upon admission that the care is covered (or if, during the ECF stay, there is a significant change in the level of care), it should take these steps:

1. Complete a "medical information form" or equivalent (by the ECF's director of nursing services, the charge nurse, or a physician) based on the attending physician's orders and the transfer hospital's medical information. A copy of the hospital's medical information summary or the attending physician's orders would generally be an acceptable substitute.
2. Forward this medical information to the intermediary within 48 hours of admission or when a change in the level of care raises doubts as to coverage.
3. The utilization review committee should review promptly each admission where there is a question of whether the required level of care is covered to help screen out claims for care which are obviously noncovered.
4. To minimize the need for recontact by the intermediary, the utilization review committee should record the skilled services it considers to justify extended care on a medical information or other form, and the information should be included with any submission of utilization review committee findings by the extended care facility to the intermediary.

F. WHAT ACTIONS WILL THE INTERMEDIARY TAKE IN ITS DETERMINATIONS?

1. Process medical information forms promptly and inform the ECF of the results.
2. Where the care is deemed covered, reimburse the ECF as long as the patient requires that level of care, up to the maximum benefits.
3. Where the ECF is conscientiously carrying out the procedures listed above in each questionable case, the intermediary will presume that a case with unclear evidence is covered up to the time when the ECF is advised that additional evidence and evaluation by the utilization review committee is required. However, if the ECF has not been following the recommended procedure for questionable cases described above in (E), retroactive denial may be made back to the date of admission or any subsequent date established by the evidence.

WPS
BLUE SHIELD
WISCONSIN PHYSICIANS SERVICE
THE DOCTORS' PLAN OF THE STATE MEDICAL SOCIETY
330 East Lakeside · Madison, Wisconsin · 53701

WISCONSIN MEDICAL JOURNAL
VOL. 67, NO. 9 SEPTEMBER 1968

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

6th Annual Work Week of Health, Oct. 1–4 in Madison Features Youth, Hippie Health

"Hippie Health" is a theme that runs through the entire 4-day Wisconsin Work Week of Health scheduled for the first week of October at the State Medical Society headquarters.

Designed in cooperation with the Wisconsin Youth Committee and nearly 30 other public and voluntary health agencies, the 1968 Work Week of Health is being presented "with and for Wisconsin Youth."

Dr. W. D. James, Oconomowoc, president of the State Medical Society, calls it a "unique experiment in communications between teenagers and the health professions."

"The idea is to give young people of high school age (especially 11th and 12th graders) an opportunity to discuss health as it affects their personal lives, their families, and their communities, now, in 1968," Dr. James said.

In keeping with the youthful theme, each person who attends will be assigned to a "communications pad" where professional advisors will be available to discuss topics ranging from accidents and alcohol to sideburns and sex.

Instead of the usual program in which the experts "talk to" the youth, the teenage conferees will "quiz the professionals."

(Continued on page 432)

PRE-REGISTER NOW! Doctor, this unusual Work Week of Health program was designed by and for teenagers (and adults who work with young people).

Do you know of any young person in your local high school (grade 11 or 12) whom you think should attend this Work Week?

Do you know an adult who might be especially interested?

Then urge them to attend one or all of the four days of program at the Work Week.

Advance registration is necessary (no charge . . . and no cost daily lunch!).

Use this pre-registration card to sign up students and others right now . . . no time to wait.

PRE-REGISTRATION FORM
NO REGISTRATION FEE

Send To Work Week of Health
Box 1109, Madison, Wis. 53701

I Will Attend the Sessions Listed Below:

WISCONSIN WORK WEEK OF HEALTH
OCTOBER 1–4
MADISON, WISCONSIN

Session	Luncheon
☐ Oct. 1—Tuesday ----	☐
☐ Oct. 2—Wednesday -	☐
☐ Oct. 3—Thursday ---	☐
☐ Oct. 4—Friday -----	☐

Please check if you intend to join us for the free courtesy luncheons.

Name	Name
Street or R.F.D.	Street or R.F.D.
City and State Zip	City and State Zip
Organization	Organization
Occupation	Occupation

Medical Societies Urged to Promote Local Community Health Week

County medical societies throughout the nation are being urged to support Community Health Week, Oct. 20–26.

In Wisconsin, medical societies and other organizations and agencies concerned with health care are urged to work together in developing local public service programs in communities throughout the state.

The week was initiated by AMA in 1962 and has become an annual event focusing public attention on medical and scientific advances, and local health problems and needs.

This year the emphasis nationwide is on educational campaigns concerning drug abuse, fitness, and health careers.

A complete kit of program aids on each subject is available through the State Medical Society office in Madison.

Daily Schedule for Work Week of Health

The 1968 Wisconsin Work Week of Health presents a new dimension in programing as well as content. Since the idea is to stimulate communication on health between teenagers and professional persons, the program process puts emphasis on discussion.

Each person attending will be assigned to a "communications pad," a room where he can join with about 50 other persons in a 1¼-hour discussion of each topic with qualified "professional advisors" from Wisconsin and around the nation.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio–economic interest to physicians and others.

Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1968 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thayer, Director of Socio–Economic Medicine.

The daily schedule, regardless of topics, will be as follows:

9:15 a.m. Greetings

9:30 a.m.–10:45 a.m. First Session

Break

11:00 a.m.–12:15 p.m. Second Session

Lunch

1:30 p.m.– 2:45 p.m. Third Session

Break

2:50 p.m.– 4:05 p.m. Fourth Session

Library to Help Visual Handicapped

A new Library for the Blind and Physically Handicapped to serve the entire state is now centered at the Milwaukee Public Library.

Anyone who is unable, because of a physical handicap to read a book in regular type for half an hour comfortably may receive Talking Books, taped books, braille books, and large print books at no charge.

Physicians knowing patients or other persons who might qualify for this service are urged to contact Mrs. Dorothy B. Haas, Librarian for the Blind and Physically Handicapped, Milwaukee Public Library, 814 W. Wisconsin Ave., Milwaukee, 53233, or telephone (414) 276–7578.

YOUTH ADVISORY COMMITTEE

A group of Wisconsin young people have provided advisory help in planning the 1968 Work Week program. They are:

Wisconsin Youth Committee
- Greg Laska, Wausau
- Debbie Homan, Ashland
- Myles Mullikin, Cuba City
- Tom Leitzke, Madison
- Pete Brandl, Wausau
- Mrs. Jeanne O'Connor

1968 Governor, Badger Girls State
- Karen Borgh, Wauwatosa

1968 Governor, Badger Boys State
- Keith Bakken, Mount Horeb

43 GROUPS CO-SPONSOR WORK WEEK OF HEALTH

The 6th Annual Work Week of Health is presented by the State Medical Society of Wisconsin in co-sponsorship with the following agencies:

American Cancer Society, Wisconsin Division
American Medical Association
Arthritis Foundation of Wisconsin
Automobile Association of America
Badger Girls State
Badger Boys State
Coordinating Council for Higher Education
Governor's Committee on Children and Youth
March of Dimes
Marquette School of Medicine
Wisconsin Council on Alcoholism
State Department of Health and Social Services
- Division of Family Services
- Division of Health
- Bureau of Comprehensive Health Planning
- Division of Mental Hygiene
  - Alcoholism Services
- Division of Vocational Rehabilitation

State Department of Nurses
State Department of Public Instruction
State Department of Transportation
United Community Services of Greater Milwaukee
- Community Planning

Wisconsin 4-H Clubs
University of Wisconsin Medical School
State Board of Vocational, Technical & Adult Education
Wisconsin Association of Licensed Practical Nurses
Wisconsin Easter Seal Society
Wisconsin Law Enforcement Officers Association
Wisconsin Nurses Association
Wisconsin Anti-Tuberculosis Association
Wisconsin Heart Association
Wisconsin Youth Committee for Community-Youth Participation
Wisconsin Hospital Association
Wisconsin Council of Churches
Wisconsin Council of Catholic Women
Wisconsin Council of Safety
Wisconsin Regional Medical Program
Wisconsin Association for Mental Health
Wisconsin State Medical Assistants Society
Wisconsin League for Nursing
Wisconsin Pharmaceutical Association
Wisconsin Health Council
Wisconsin Education Association
Wisconsin State Dental Society
Wisconsin Association of Nursing Homes, Inc.
Wisconsin Association for Retarded Children
Wisconsin Council of Homes for the Aging
Wisconsin State Commission on Aging
Wisconsin Dietetic Association

WORK WEEK

(Continued from page 431)

The Work Week program is printed in full on page 433.

The Woman's Auxiliary to the State Medical Society has a leading role in the success of the program since it is working closely with high schools, local youth groups, and others to assure statewide attendance of students at the conferences.

PROGRAM—WISCONSIN WORK WEEK OF HEALTH—OCT. 1–4

TUESDAY, OCT. 1

8:30 *REGISTRATION*

9:15 *GREETINGS*

The Honorable Jack B. Olson, Lieutenant Governor of Wisconsin, Madison

W. D. James, MD, President, State Medical Society of Wisconsin, Oconomowoc

Greg Laska, President, Wisconsin Youth Committee, Wausau

9:30 to 4:00 *HIPPIE HEALTH*

Should You Keep Off (or on) the Grass?

Professional Advisor: Herbert A. Raskin, MD, Member, American Medical Association Council on Mental Health Committee on Alcoholism and Drug Dependence, Detroit, Mich.

Sex and the Teenager

(Speaker to be announced)

Are Sideburns a Health Hazard?

Professional Advisor: David Smith, MD, Director, Drug Abuse Screening Unit, San Francisco General Hospital

Help, Health and Hope

Professional Advisor: William B. Walsh, MD, Director, Project HOPE, Washington, D.C.

WEDNESDAY, OCT. 2

8:30 *REGISTRATION*

9:15 *GREETINGS*

The Honorable Robert Knowles, President Pro Tempore, Wisconsin Senate, Madison

R. E. Callan, MD, President-elect, State Medical Society of Wisconsin, Milwaukee

Keith Bakken, 1968 Governor of Boys State, Mount Horeb

9:30 to 4:00 *THE CARE-FREE YEARS*

Hawk, Dove or Chicken?

(How to keep your driver's license and stay alive)

Professional Advisors: Don Gehrmann, Supervisor, Traffic Safety Education, State Department of Public Instruction, Madison; and J. L. Weygandt, MD, Chairman, Commission on Safe Transportation, State Medical Society of Wisconsin, Sheboygan Falls

Sports on Trial

Professional Advisor: Allan J. Ryan, MD, Chairman, American Medical Association Committee on Medical Aspects of Sports, Madison

So You've Had An Accident

Professional Advisor: Frederick Bunkfeldt, Jr., MD, Milwaukee

Why Students Crack Up

Professional Advisor: J. C. Westman, M.D., Professor of Psychiatry, University of Wisconsin Medical School, Madison

THURSDAY, OCT. 3

8:30 *REGISTRATION*

9:15 *GREETINGS*

The Honorable Harold V. Froehlich, Speaker, Wisconsin State Assembly, Madison

W. D. James, MD, President, State Medical Society of Wisconsin, Oconomowoc

Karen Borgh, 1968 Governor of Girls State, Wauwatosa

9:30 to 4:00 *HOW TO TURN HEALTH OFF (AND ON)*

How to Be One of the Beautiful People

(Health and your good looks—cosmetics)

Professional Advisor: Marjorie Bauer, MD, Los Angeles, Calif.

The Tappa Kegga Da Fraternity

(Teenage drinking)

Professional Advisor: Martin D. Kissen, MD, Director, Institute for Alcoholism and Narcotic Addiction, Philadelphia, Pa.

Macrobiotics and Other Nutty Diets

Professional Advisor: F. J. Stare, MD, Professor of Nutrition, Harvard School of Public Health, Cambridge, Mass.

LSD and Other Many Splendored Things

Professional Advisor: Joseph M. Benforado, MD, Assistant Clinical Professor of Medicine, University of Wisconsin Medical School, Madison

FRIDAY, OCT. 4

8:30 *REGISTRATION*

9:15 *GREETINGS*

R. E. Callan, MD, President-elect, State Medical Society of Wisconsin, Milwaukee

Miss Teenage Wisconsin

9:30 to 4:00 *HEALTH HORIZONS UNLIMITED*

Smoking and Other Burning Issues!

Professional Advisor: R. J. Samp, MD, Assistant Professor of Clinical Oncology, University of Wisconsin Medical School, Madison

Call the Fuzz, I've Been Taken

Professional Advisor: Irving Ladimer, SJD, Vice-president, Food, Drug and Cosmetic Division, National Better Business Bureau, New York City

How to Kick the Habit

(Two who did—members of Encounter, Inc., a group of teenage ex-addicts)

The Press Meets the Experts

E. J. Nordby, MD, Chairman, Council, State Medical Society of Wisconsin, Madison

Representative of State Dental Society

Representative of State Pharmaceutical Association

Representative of Wisconsin Nurses Association

Outline Health Care Programs for Indians

The Indian who lives in Wisconsin can, like most other people, get his health care where he wishes and pay his own way.

Or, if he wants to force the letter of the law, he can "try" to have all his health care paid for by the Division of Indian Health of the United States Public Health Service.

Or, as it happens in most cases, he can pay his own way when he can and ask for help from a variety of special sources for the rest.

Focus on the Indian's health care in Wisconsin has been stimulated by recent communications between the Public Health Service Indian Health Field Office at Bemidji, Minn., and the State Medical Society of Wisconsin.

The Bemidji Indian office is the headquarters and governing authority for health care, health education, and environmental health programs for all Indians in Wisconsin who wish to benefit from its programs.

The activity stems out of an act of Congress in July 1955 which created the Division of Indian Health under the USPHS. It was charged with "raising the health of the Indian people to the highest possible level."

A three-pronged attack of prevention, cure, and rehabilitation was launched throughout the nation, including Wisconsin.

The Indian Division does not itself provide all services. Although the law says that all Indian people are eligible for services, the fact that there isn't enough money to give everyone care has made it necessary for the Indian Division to set priorities.

To be eligible for Indian Division services an Indian must be "living on or near a reservation." Next, he must be "considered an Indian by the group with whom he lives."

The Bemidji Indian Office says it is only a "final resource, not a primary resource" for health services:

1. Indians who can pay their own way in health care, can do so and get their care where they wish.
2. Those not able to pay for their own care are assisted in using medical programs available to the rest of the population such as Medicare, Medicaid, Veterans benefits, Crippled Children's services, Vocational Rehabilitation and so on.
3. If there are still gaps, the Indian Division will fill them in by paying for services unavailable through any other programs for those who cannot pay.

In Wisconsin, Indians have services available in two basic ways through the Indian Division:

1. At Red Cliff, Bad River, Lac Courte Oreilles, Lac du Flambeau, Forest County Potawatomi, and Mole Lake Sokaogon Communities, the Division of Indian Health enters into direct vendor contracts with hospitals, physicians, dentists, and pharmacies. The Indian living in these areas must use the vendor with whom the Division has a contract, and eligibility is determined by application to the PHS Indian Office in Bemidji.

2. For the St. Croix group, Stockbridge–Munsee, and part of the Winnebago group (those living in Wisconsin Rapids), the Indian Division contracts with the county welfare departments to administer the medical program. Eligibility is the same as that for Wisconsin Medicaid, and the person must make application at his county welfare office. If accepted under Medicaid, his services are rendered with free choice and bills paid in the usual Medicaid pattern.

Public health nursing services are available to Indians under contract as follows:

Bad River Reservation: Ashland County Public Health Nurse.
Red Cliff Reservation: Bayfield County PHN.
Lac Courte Oreilles Reservation: Sawyer County PHN.
Lac du Flambeau Reservation: Vilas County PHN.
Forest County Potawatomi Community: Forest County PHN and Mole Lake Sokaogon Community.

An environmental health office in Rhinelander is supported by the Indian Division and has two engineers who provide sanitarian and other services for the several reservations in the state.

Health education programs for local Indian groups may be developed with assistance from a health educator working out of the Bemidji Indian office.

IMPORTANT REMINDER

Prior notification is required on non-emergency medical care of Indians in Wisconsin if the USPHS Division of Indian Health is expected to pay the bill.

Notification within 72 hours is required for emergency care.

The above information is published at the request of the Bemidji Indian Office director under date of Aug. 15, 1968.

WHEN YOU HAVE QUESTIONS

Any inquiries or problems involving health care for Indians in Wisconsin are to be directed to:

Asst. Indian Health Area Director
PHS Indian Health Field Office
203 Federal Building
Bemidji, Minn. 56601

HEALTH STUDY OFFERED

Oshkosh has just completed a thorough "physical examination" of itself . . . a searching study of what it has and what it needs for the health of its residents.

The findings, after two years of study, urge strengthening of material and child health care. VD control, school health programs, disease detection, creation of a community health information service, and greater cooperation with other Fox Valley communities.

MDs Urged to Push Preschool Vision and Hearing Screening

Preschool hearing and vision screening programs in Wisconsin are being urged by several public and voluntary agencies in the state, including the Divisions on Vision and Hearing of the State Medical Society.

As an aid to those interested in such programs, Dr. Horace K. Tenney, III, Madison, medical director of the Bureau for Handicapped Children of the State Department of Public Instruction, suggests that physicians review a recent statement developed by the Wisconsin Hearing Conservation Program:

"For fifteen years or more the Bureau for Handicapped Children has had a Hearing Conservation Program designed to detect and assist the school age children with hearing difficulties. Preschool children are seen occasionally in this program by special referral, but the majority of children seen are over six years of age.

"Steps involved in this program are:

"(1) screening—done by volunteers using a portable pure tone audiometer,

"(2) recheck on the children who fail to pass the screening done by an audiologist or someone specially trained to do this,

"(3) medical examination by an ear-nose-throat doctor at one of the traveling otologic clinics. His diagnosis and recommendations are sent to the family physician,

"(4) follow-up on the recommendations to make sure that all is done for the child that can be done.

"With the recognition of the advantages of detecting hearing difficulties as early as possible, the Bureau has hired an audiologist to plan a statewide program for the younger age group. While the specific details of the program have not been worked out yet, the general format will probably follow that now in operation for the school children.

"The goal of the program is to screen the hearing of as many children as possible under age six and to set up a referral pattern for testing any children suspected of having hearing difficulties.

"There are several techniques for screening preschoolers and one of the more recent ones has received attention in national publications. This approach is called VASC meaning Verbal Auditory Screening for Children. Whereas most screening methods have used tones as the stimulus, VASC, as the name implies, uses a verbal stimulus.

"No clear cut superiority exists for use of either pure tones or speech as the stimulus as applied to screening techniques for the preschool child.

"As the Wisconsin program is initiated, consideration will be given to all known methods. The decision of which one or ones are most appropriate will then be made based on the research and experience of others as well as our own judgment and investigations.

"Vision screening has been traditionally done in Wisconsin by nurses or teachers in the schools. There is no state agency which coordinates separate programs as the Bureau for Handicapped Children does for hearing.

"The Division of Health, however, is planning to hire a full time person to work in the field of vision screening, paying particular attention to preschool children.

"Until this position is created and filled, communities wishing to start programs in preschool vision screening can obtain help from the Wisconsin Society for the Prevention of Blindness, 312 East Wisconsin Avenue, Milwaukee, Wisconsin 53202."

NEW CHAIRMAN DIVISION ON AGING

Dr. Craig Larson, Milwaukee, has been appointed to the chairmanship of the Division on Aging, Commission on State Departments of the State Medical Society.

Dr. Larson's appointment was announced by Dr. E. J. Nordby, Madison, chairman of the Council. He fills the vacancy created by the death of Dr. G. G. Stebbins, Madison.

CRAIG LARSON, MD

FRANK DREW, MD

Reappointed Director Regional Medical Program

Dr. Frank E. Drew, Milwaukee, past president of the State Medical Society, has been reappointed by the Society as its representative on the Board of Directors of the Wisconsin Regional Medical Program, Inc.

Others on the board are Edmund Fitzgerald, Milwaukee; Fred Harvey, Harrington, Madison; Edward J. Connors, Madison; Robert F. Froehlke, Stevens Point; and Orval H. Guenther, Wauwatosa.

WON'T TREAT PATIENTS, SAYS WISCONSIN RMP

Direct treatment of patients and the operation of hospitals or medical centers is not in the plans of the Wisconsin Regional Medical Program.

Administrators of the program declare the intent in Wisconsin is clearly to encourage and cooperate with existing institutions and organizations to develop added resources of this kind where they are needed.

Similarly, WRMP says it will confine its "service to patients" activity to assisting health institutions and professionals to do a better job of reaching patients with the latest in medical knowledge and techniques.

Health Insurance Grows

Eighty-seven percent of the civilian population under 65 of the U. S. is now covered by private hospital insurance, and of these 93% had surgical coverage, and 76% had medical expense protection.

Guidelines for Professional Courtesy

The Council of the State Medical Society has acted to distribute guidelines for the assistance of physicians on questions of professional courtesy.

At a recent meeting, the Council asked that all physicians be informed of the statement of the American Medical Association's Judicial Council on this subject. The AMA Guidelines are published in full as follows:

"The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their mutual concern to apply their learning for the benefit of one another as well as their patients. The Judicial Council reaffirms and endorses the principle of professional courtesy as a noble tradition that is adaptable to the changing scene of medical practice.

"Professional courtesy is not a rule of conduct that is to be enforced under threat of penalty of any kind. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he shall allow a discount from his usual and customary fees for the professional services he renders, and to whom he shall render such services without charge as professional courtesy.

"The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

"1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

"2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.

"3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

"4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him."

The above guidelines were adopted by the AMA Judicial Council on June 17, 1967.

PRIORITIES SET FOR HOSPITAL CONSTRUCTION

Hospital construction and remodeling is getting its annual "transfusion" of federal grants-in-aid under the Hill–Burton Act.

In Wisconsin the program is administered by the Council on Hospital Construction within the Division of Health.

State Health Officer E. H. Jorris, MD, reported that federal monies totaling $5,361,806 are available for allocation in Wisconsin. Since federal funds are provided only for 40% of the total costs, the other 60% must come from local sources. If all current funds are allocated, it will permit construction of facilities costing $13,400,000.

Under the state plan, communities assigned the highest priorities in the hospital construction category are: (1) Ladysmith, (2) Ashland, (3) Dodgeville, (4) Merrill, (5) Chippewa Falls, (6) Platteville, (7) New London, (8) Berlin, (9) Janesville, and (10) Wautoma.

Highest priorities for nursing homes and chronic disease hospitals are: (1) Woodruff, (2) Ashland, (3) Antigo, (4) Shawano, (5) Tomahawk, (6) Wautoma, (7) Watertown, (8) Platteville, (9) Columbus, and (10) Algoma.

Develop Health Guide for Jr.-Sr. High Athletic Competition

A guide for interscholastic athletic disqualification at the junior and senior high school level is being prepared by the Division on School Health, and final approval rests with the Commission on State Departments of the Society.

Participants in football, basketball, wrestling, hockey, and baseball are particularly affected by the guide. However, there are aspects of the guide which will be of value to physicians in determining disqualification in other sports as well.

The guide suggests that there are two major considerations for restricting persons from participation in athletics:

1. Is there a disease or condition which prevents the individual from competing fairly with persons that are normal?
2. Is there a disease or condition which might be aggravated by athletic competition?

The guide outlines the relationship of student, parents, physicians, school and WIAA in qualifying athletes for participation.

The guide outlines conditions considered disqualifying with special emphasis on maturity, paired organs, diseases of the cardiovascular system, hernia and hydrocele, the nervous system, orthopedic conditions, epilepsy and diabetes, skin diseases, asthma and other respiratory conditions.

Further information will be provided the society membership on completion of the guide.

Post Pay Plan Readied by WPS–Blue Shield

Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society, has announced plans to experiment with postpayment financing of health care expenses as a companion to its regular health insurance coverages.

Under the plan, eligible WPS subscribers would be granted "instant credit" for needed services not paid for by their WPS contracts.

They would receive a consolidated monthly billing for health services and could budget the payments over a longer period if they wished.

The trial WPS plan will offer postpayment to eligible group subscribers. At the start, it is expected to include not only doctors' services, but drugs, dental care, special medical supplies and equipment, and possibly hospital and nursing home care.

Dr. E. M. Dessloch, Prairie du Chien, chairman of the SMS Commission on Medical Care Plans, said, "We are fast closing the gaps in coverage for items of health care which are insurable. Postpayment will help those people who, although able to do so, have not budgeted for certain uninsured or partly insured costs of illness."

"This will give the patient or his family a breathing period on costs at the time his chief concern is the best possible care for early recovery," Doctor Dessloch said.

WPS believes its present Blue Shield policies for hospital, surgical–medical care, cover about two-thirds of the sickness or accident expenses for its subscribers. This is twice as good as the reported national average.

Even so, many people do not buy the added coverages which WPS–Blue Shield offers, such as outpatient diagnostic services, drugs, dental care, nursing home and home care.

"The fact remains that many health insurance policyholders in this state pay 30% to 50% or more of the expenses of some illnesses out of pocket," Doctor Dessloch declared.

WPS leaders believe the combination of broad insurance coverage with a postpayment plan will make needed care available while holding down utilization or "frivolous use" of services.

Continuing professional review of fees and utilization will be part of the new plan as it is in present WPS–Blue Shield operations.

Doubt WRMP Is Limited to Only Four Diseases

There is widespread agreement that WRMP is a cooperative program through which medical schools, physicians, hospitals, nurses, voluntary health agencies and others, in the Wisconsin region, can get and give each other more and quicker assistance in combatting certain serious diseases.

But there is less agreement as to what diseases or conditions are or might be included in the program.

The law as passed in 1965 declared the program was aimed at "heart disease, cancer and stroke and related diseases."

The phrase "related diseases" is still undefined, and apparently can go as far and wide as the RMP administrators in each region desire.

Further, Congress has since added emphysema to the list of specific conditions under the purview of RMP.

While not so elsewhere, the Wisconsin Regional Medical Program has thus far limited carefully its projects to those specifically identified by the law.

Dr. John S. Hirschboeck, WRMP Program Coordinator, feels that current philosophy at the national level is to approve only projects that adhere rather strictly to the enumerated disease conditions.

"It is my personal intention to move firmly but carefully within the obvious limitations of the program," Dr. Hirschboeck said.

Thirteen of the 42-member Advisory Committee are physicians, as are one of the seven member Board of Directors, six of the 14 member Planning Committee, and almost all of the members of the disease study groups.

Want to Bowl?

Would you be interested in participating in a State Medical Society Bowling Tournament (physicians and their wives) to be held in February 1969? If so, write to SMS Bowling, Box 1109, Madison, Wis. 53701. A committee of physician bowlers will contact you.

NURSING HOME QUITS MEDICARE IN PROTEST

A Green Bay nursing home has withdrawn from participation in Medicare effective Sept. 1 to dramatize its objections to "the principles of reimbursement, operation, and certification currently used by the bureaucrats" running the federal program.

"We don't want to deny the elderly help with their medical costs, but the inherent difficulties in Medicare can only be corrected by major changes," according to Donald Idzik, president of the board of directors of Grancare Nursing Hospital in Green Bay.

He said the institution would continue to participate in the Medicaid (Title 19) programs.

One major difficulty cited by Idzik is that in many cases governmental bureaus which approve Medicare payments won't accept the local medical review committee's judgment that continued medical care is necessary, even though physicians serving on the committee certify to that need.

"The decisions of professional men are deliberately ignored and instead the Social Security Administration issues directives arbitrarily limiting benefits," he commented.

There is indication that other nursing homes are considering withdrawal from Medicare unless there is a remedy for these problems, he said.

SMS Hot Line

PUBLIC HEALTH SAFETY is in jeopardy, state public health officials charge, as a result of "huge reductions" in health department staff and expenditures brought on by state legislative reorganization. Dr. E. H. Jorris, State Health Officer, and others in the Division of Health contend that reorganization resulted in cutting sanitary districts in half and "sharply slashing" the number of engineers, sanitarians, inspectors, and other skilled public health personnel. At the same time new demands for sanitary surveys of swimming beaches, pollution control, mushrooming housing developments, and disease problems associated with recreation have greatly increased the need for service.

WISCONSIN OPTOMETRIC ASSOCIATION announces that 1970 is the year "for the end of commercialism." In an editorial published in the July-August 1968 issue of the Wisconsin Optometrist, the president of WOA states: "Let us all work toward that goal and the quickest way to achieve it is through organized optometry."

DRUG ABUSE INFORMATION is now available in complete and compact form from the State Medical Society of Wisconsin and the AMA. With the information, a full-scale local publicity program can be formulated. Interesting, concise information is provided on LSD, glue sniffing, marihuana, barbiturates, narcotics, and amphetamines. Just contact State Medical Society for Drug Abuse Packet.

WPS PROVIDES STUDENT COVERAGE for health care at 14 universities and colleges in Wisconsin protecting a total of nearly 30,000 students. Starting this September students at these institutions will have WPS Special Service coverage: Whitewater SU, Platteville SU, Eau Claire SU, Oshkosh SU, Superior SU, La Crosse SU, Stout SU, Dominican College, Carthage College, Lakeland College, Sheboygan County Teachers, Richland Campus of Platteville SU, members of the Wisconsin Student Association at the University of Wisconsin Madison campus, and Marquette University.

IN-DEPTH TEACHING PROGRAMS are being scheduled this winter as part of the teaching service of the Charitable, Educational and Scientific Foundation of the SMS in cooperation with supporting agencies. Each will begin with a wet clinic at the UW Medical School in the a.m., and lunch and lectures at SMS in p.m. Dates are: Dec. 4, 1968 (Coronary Care Units—Two Years Later), Jan. 16, 1969 (subject to be determined), Feb. 19 (Respiratory Therapy), and Mar. 20 (subject to be announced).

ATTENTION COUNTY SOCIETY PROGRAM CHAIRMEN . . . SMS President W. D. James and President-elect R. E. Callan are completely available to be "drafted" for appearances at county medical society meetings. Contact SMS Headquarters, Madison [tel. (608) 257-6781] . . . please allow 30 days lead time to permit them to adjust their schedules . . . but don't overlook this opportunity.

DR. WILLIAM S. MIDDLETON and the William S. Middleton Medical Library of the University of Wisconsin. With the expanded facilities available in this splendid building (the gift of the University of Wisconsin Medical Alumni Association) the Medical Library Service is increasing its efforts to provide physicians with a responsive mechanism for library service at the local as well as the statewide level.

SPECIAL TO THE JOURNAL

Medical Library Services in Wisconsin

By VIRGINIA HOLTZ and HELEN CRAWFORD
Madison, Wisconsin

INFORMATION AND EDUCATION are the inseparable Siamese twins of medicine. Without one the other will not thrive. Without both, physicians cannot be expected to provide the best in up-to-date medical care for their patients.

Traditionally each doctor had his own journal and text-book library and each hospital or clinic its collection of several hundred books and a number of journal subscriptions. The need for such a service in the hospital was and is recognized by those responsible for accreditation. *The Standards for Hospital Accreditation*[1] call for each institution to have a Medical Library "according to the needs of the hospital." It requires the hospital to furnish the basic ingredients: facilities, books, journals, and personnel. To comply with the minimum standards, a hospital library must have "modern textbooks in the basic sciences, particularly in anatomy, physiology, pathology, microbiology, and pharmacology. It should also have textbooks and current periodicals relative to the clinical services maintained in the hospital. Beyond these minimum requirements, the scope of library services depends on the needs of the hospital and the medical staff."[2]

For help beyond that available in his hospital and personal collections, the physician in Wisconsin was able to draw on such outside resources as the Medical Library Service of the University of Wisconsin Medical School, which provided statewide service, and Marquette Medical–Dental Library, which bore the responsibility for the Milwaukee area. Further assistance was available from the American Medical Association, American Hospital Association, American Dental Association, other similar organizations, and ultimately from the National Library of Medicine and its predecessors.

All of these services have grown and changed in size and scope over the years and each has filled and continues to fill a real need. They operate independently of each other, and areas of overlap as well as areas not covered have gone relatively unnoticed until the ever-growing information pile-up revealed the weaknesses of the existing service structure.

Miss Holtz is Associate Librarian and Director of Medical Library Service and Miss Crawford is Associate Professor and Medical Librarian of the Middleton Medical Library, University of Wisconsin Medical Center.

The phenomenon, commonly known as the information explosion in science, has been explained in many ways by many people. According to Overhage and Harman[3] we face "a doubling in the output of scientific information every 10 years." Responsibility for this growth is placed at the door of an ever-expanding research effort. In a nation where the expenditure for research has grown from $45 million in 1940 to $715 million in 1960 with a projection for 1970 of $3 billion,[4] the parallel growth of scientific information should not be surprising.

One side-effect of this production of new information has been a proliferation of publications in medicine and the related sciences. Since the beginning of the century the number of medical journals has quadrupled.[4] Indexes and other bibliographic apparatus needed to provide access to them have been pushed to the breaking point in an effort to keep abreast of the information output. New indexes and abstracting devices are appearing with great frequency, and the size and cost of the major biomedical tools are following a sharp curve upward.

Mechanized searching services of great variability in scope of coverage and output multiply until the old science-fiction inventions, the "indexes to indexes" and "indexes to indexing services" have become a reality. Necessity has played its part in the creation of new and welcome tools such as *Current Contents* and *Science Citation Index*. Not only has the number of medical publications increased but the types of publications have multiplied. In addition to the traditional books and journals, we are confronted with increasing numbers of Congresses, Symposia, Government Documents, report literature, and unpublished data available from an assortment of information sources, as well as information in the nontraditional forms of films, tapes, slides, and the like.

The hospital library often is totally inadequate for the needs of its potential users

All of these developments have played a part in creating the problems confronting the hospital library today. Thus, this branch of the hospital, which in many cases has already atrophied from the combined evils of neglect and disuse, is as often as not found to be totally inadequate for the needs of its potential users. According to Dr. Luther Terry, former Surgeon General of the U.S. Public Health Service, "The tremendous quantities of new information that are being generated by our massive research effort have overwhelmed the traditional channels of communication, which were developed to meet vastly different conditions."[5]

Of the estimated 6,389 specialized health-related libraries in the United States identified by the President's Commission on Heart Disease, Cancer and Stroke,[6] over 4,000 were considered legitimate objects of concern to the commission. Almost exactly half of these libraries were located in hospitals.

While the basic problem is the same age-old one of communicating scientific knowledge to the user, the element of speed has entered the picture. A fast pace in the development of new knowledge in any subject goes hand in hand with the need for speed in disseminating this information. In medicine the need for speed is critical.

Rapid dissemination of new developments in medicine and science intensifies need for medical journals

The rapidity with which new developments and discoveries appear has made it more essential than ever that *new* editions of books be on the shelves. This same time factor intensifies the long-term trend towards dependance on medical journals as opposed to books. The rate at which fields of study are expanding, sub-dividing, and spilling over into previously unrelated areas creates an ever-growing need for more journals and more indexing devices. The old standard specialty journals can no longer contain all that physicians and other health-related personnel need to know about their subjects. The increasing rate of change in medicine, its sub-fields, and related areas makes facilities for continuing education, formal and informal, a crucial and necessary function of every institution with an interest in medical care.

The place of the hospital and clinic library in the communication chain is an important one. According to Doctor Terry the hospital should be the pivotal agency for health communication in most communities and he puts forward the premise that "the community hospital will become increasingly important in health education for all types of health practitioners and the general public."[5] He feels that since these organizations constitute the "arena" in which modern medicine is or should be applied, that it is urgent that they be "tuned in to the frequencies on which research information is broadcast."[5]

In view of the predicted importance of the hospital library link in the information chain, it is not reassuring to read the results of the 1962 national survey of hospital library resources conducted by the American Hospital Association Division of Research.[7] Its authors conclude that "vast improvements in holdings, staff and service must be achieved" for the libraries to function properly as communication and reference centers in matters concerning health.

In order to collect data to find where Wisconsin stood in relation to the national scene, the Medical Library Service conducted the *Wisconsin Survey of Health Information Facilities*. Last summer 250 questionnaires were mailed to hospitals and clinics throughout the state regardless of their size. By the end of 1967, 100 forms had been returned and some interesting tabulations made.

Among those answering were 66 general hospitals, 7 psychiatric hospitals, 6 other special service units (T.B., Chronic Disease and Institutional), 17 clinics, and 4 unidentified institutions. Two from the general group and one from the psychiatric are Veterans Administration units. Thirty-two of the reporting hospitals are of the 100-bed size or larger.

The only formal written standards for hospital libraries available for comparison are those published in 1953 by the American Library Association, republished in 1955, and now under revision. They are the result of a joint effort of the American Library Association, the Special Libraries Association, and the Medical Library Association.[8] Scott Adams,[9] Deputy Director of the National Library of Medicine, judges even these standards to be inadequate, although many hospitals would have difficulty meeting them. They call for hospitals of 100 beds or more to have collections of 1000 volumes of books and journals (published within the last 10 years) and to subscribe to at least 25 journals. Mr. Adams' 1964 opinion is that a more adequate collection would require 5000 volumes and 100 journal subscriptions.

Somewhere between these early and late proposals for the ideal, fall the average figures from the 1962 American Hospital Association survey in which it was found, for all sizes of hospitals, that the book collection averaged 561 titles and the journal collection 33 subscriptions per library. In the Wisconsin survey, 52 answers were received concerning collection size. Of these, 18 libraries had 561 titles or more. In this category, and almost all others, Veterans Administration hospital libraries and special libraries, such as Nursing, Psychiatric, and Laboratory facilities, reflected their special funding situations by placing high on the list. Some of the state's larger clinics show this same trend. When the collections of these groups are excluded from the results, as they were in the national survey, we are left with 9 general, short-term hospitals of the 64 reporting, having book collections which meet the national average in size. The state average for general short-term hospitals was 484, or about 80 titles below the national figure.

In an effort to determine how up-to-date the Wisconsin collections are, questions were asked concerning the number of new books added and old books discarded. Fifty-five of the 70 institutions which reported having libraries recorded having added new titles to their book collections. Eighteen, of which 9 were general hospitals, added 50 or more titles, while the 14 next in line added more than 10. Seventeen collections were not enriched by a single title; still, the overall state record is encouraging.

The discard picture, which is usually considered to reflect strongly on the currency of a library holdings, is not as bright. Only 18 reports indicated any discards at all and 8 of these were from special libraries. Considering the importance of new information in the medical and paramedical fields and the hazards of utilizing outdated material, an ongoing review policy in this area is strongly recommended. These figures also call into doubt the validity of the total collection figures. Volumes containing obsolete material are at best useless and can discourage the inquiring physician from considering the hospital library as a reliable information resource, thus further contributing to the cycle which spells obsolescence for the library itself.

The question of the number of journal subscriptions needed for the hospital medical library is more complex. The importance of the journal in medicine is unquestioned. The information is more up-to-date than that presented in the texts, and newest developments in the field are announced to the profession through this medium. Questions are raised and debates conducted via the pages of medical journals.

The old standards call for 25 subscriptions per 100-bed hospital. Mr. Adams claims 100 subscriptions are necessary to do the job. The Geissler–Yast Survey indicated the national average at 33 per hospital (all sizes) for general, short-stay hospitals; and the Wisconsin average, derived from the 56 answers obtained to this question, is 31. If the large special libraries are figured into the total, the state average rises to 42.5. However, only 23 reporting libraries have 33 or more subscriptions and 10 of these are special library collections. While approaching the national averages in this category the figures do indicate that Wisconsin's riches are poorly distributed geographically and access to some of the most commonly needed journals is poor.

Wisconsin survey of health information facilities revealed collections below national average

William Kurth, in his *Survey of the Interlibrary Loan Operation of the National Library of Medicine*,[10] found that hospital libraries accounted for the second highest number of loans in the United States, with only Federal Government medical libraries outdoing them in the percentage column. Adams feels this further reflects on the inadequacy of hospital libraries in general. Although the National Library of Medicine is intended to *supplement* collections of material available regionally, analysis indicates that the most frequently requested journals are those that should be generally accessible: *Lancet; British Medical Journal; Journal of the American Medical Association; New England Journal of Medicine; Surgery, Gynecology* and *Obstetrics*, some of the A.M.A. Archives, and others of this type.

Wisconsin's Medical Library Service records of loans to hospitals, clinics, and physicians indicate a similar pattern. Totals from a five-year survey indicate that the *Journal of the American Medical Association* leads the list as the most requested journal followed by the *New England Journal of*

Medicine, Lancet, British Medical Journal, American Journal of Medicine, and other titles which should be in a general collection. In a one-year period these five journals accounted for over 500 loans in the state.

Journals present several unique problems. One is the need for planning space to shelve a rapidly expanding collection of this type and the other is a need for a quick way to find specific information when needed. Fortunately there are answers to both of these most pressing questions.

Large and small studies covering various sized geographic areas all confirm that the heaviest use of a journal falls within the first 10 years. After this period a "decay" in volume of use begins and an additional 50% loss occurs for each decade thereafter. These figures present a valuable guideline for determining the optimum age of the hospital library journal collection, depending upon the size and nature of the user population. In Wisconsin, only 25 of the reporting libraries kept their journals for this maximum-use period, with all others discarding issues after a shorter span of time!

A valuable tool for quick reference to medical and related journals is the Index Medicus

The question of access to the information in journals is immediately apparent. While a collection of five journals covering only a year or two can be approached via the annual indexes of those journals, a larger collection which retains more titles for a longer period of time makes this approach obsolete and further discourages use of the collection. The health professionals in the United States are fortunate in having in the *Index Medicus* an inexpensive and comprehensive index to medical and related journals. Yet, only 22 libraries reported having the tool. Since this index not only gives the user quick access to articles in the journals which the library *does* have but also indicates where further information may be found in other quickly obtainable journals, this lack is one of the most serious of those revealed by the survey.

Most of the weaknesses in the hospital or clinic medical library are magnified by a lack of trained personnel. Not every hospital needs or can afford to hire a trained professional librarian. Every such institution *does* need to have someone whose first responsibility is the library and who is trained in the basic arts necessary to organize, maintain, improve, and utilize the collection. Trained personnel can not only utilize to the full those resources at hand but can assist the physician and other personnel in tapping the resources outside the home collection.

Only 9 of the reporting libraries had full-time professionals, 7 had half-time librarians, and 2 had full-time nonprofessionals with library training. Three others had one to nine hours of professional assistance each week. In most other cases where personnel of any kind was reported, library duties were carried out by the Medical Records Librarians who gave from one to five hours per week to the job. There seems to be a basic misunderstanding about the differences between a Medical Library and a Medical Records Library which are similar in name only, with quite different skills required for each. Only one hospital librarian in the state has attended the American Hospital Association's institute on hospital librarianship, although four of these workshops have been held since 1959. Since only 16 respondents to the questionnaire expressed an interest in a Wisconsin workshop on library techniques for the nonprofessional, a general lack of interest in training for library personnel seems evident, to the added detriment of library service in the hospital.

Several major conflicts would seem to need examination before an improvement in information and library services can be expected. The medical community, like the general community, has traditionally come to think of the library as a place where books and journals are kept. While this is, in a sense, true, today's library is, or should be, much more. It is the place where library and information service is offered. The key word here, and the one that will make the difference in what benefits the hospital will derive from its investment, is service. Any investment in books, journals, and the newer communication media must be matched by an investment in someone to service them . . . in the same way that any complex bit of diagnostic or therapeutic equipment needs its technician in order to operate properly. The physician, who is already pressed for time, cannot be blamed for not using a collection which is not adequate and not organized for fast retrieval of information. If he cannot obtain assistance in locating those answers to his question which are in the collection, much less in finding what might be available from other sources, there is indeed little reason for his placing any emphasis at all on the maintenance of a library in any form. A little training and organization can go a long way.

Another major conflict is the one between what the hospital can afford to offer and information needs of the physician and other personnel. While there seem to be definite boundaries to such things as budget and space, there is, for health-related personnel, an unlimited "need to know." To this end the hospital must apply every available resource. Somehow a way must be found to bring within the reach of the hospital those forms of medical communication which will effectively make available to its practitioners the entire universe of medical knowledge in its most current form as well as its retrospective form.

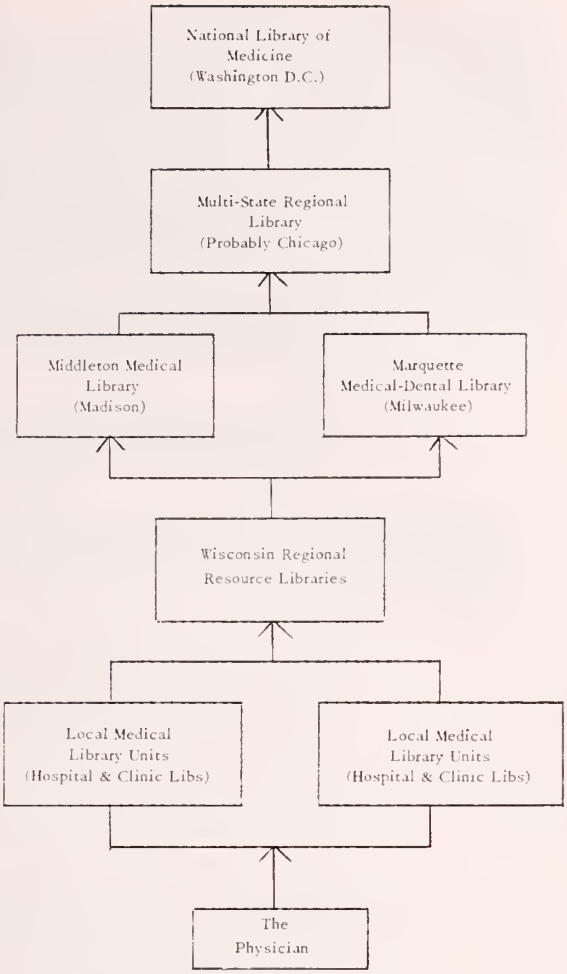
Although amazing developments in the machine fields offer great promise for the future, we have a present-day problem which must, at the moment, be handled with present-day capabilities. On a much

larger scale the National Library of Medicine has found that it can make most effective use of its vast resources by developing a regional system and educating its public in the availability, extent, and use of these materials and services. The 1967 Wisconsin survey has indicated that the same sort of regional plan might well be one answer to the hospital and clinic library problems which confront us. This study has indicated a feast or famine situation in many areas of the state with a concentration of source collections in the densely populated Milwaukee and Madison areas and very little of anything in some of the outlying counties. Interestingly, however, there is at least one good-sized collection in almost every region as established in the *Wisconsin State Plan for Hospital and Medical Facilities.*[11] While no plan can or should relieve the hospital or clinic of the responsibility for maintaining a reasonable collection of the basic tools of its trade, a network of regions, each with its own larger resource library on which to draw for important but less frequently used materials, would improve the hospitals' ability to furnish much needed information in a hurry. The large collections of the two Wisconsin medical schools are traditionally available to the physicians of the state and this type of organization would merely formalize their services. Such a network could serve not only as a pipeline for materials but would be a natural organization through which to offer further training for the library personnel. As applicable machine advances become available they could be applied to this ready-made system.

Aside from the statewide services, there are already small component parts of this organization in operation. Some hospitals have cooperative buying arrangements with neighboring institutions, thereby doubling the value of their budgets. Some very small institutions depend, as a matter of course, upon their larger counterparts.

In at least one area in the state, two larger organizations have joined together and offered their services to smaller units in their immediate geographic region. Many of these informal arrangements exist because of the initiative or superior training of certain individuals, or good will between various institutions. Further developments in this direction, formalizing ties and extending services, can only serve to stabilize and expand this budding network.

With the new and expanded facilities of the William S. Middleton Medical Library at the University of Wisconsin Medical Center, the Medical Library Service is increasing its efforts to provide physicians with the best possible mechanism for prompt and efficient retrieval of medical information. Further reports on the services of the Library will be published in subsequent issues.



A proposed traffic pattern for material and information requests originating at the local level.

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THE HOUSE OF DELEGATES IN SESSION

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STATE MEDICAL SOCIETY OF WISCONSIN
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REPORTS AND PROCEEDINGS
1968 ANNUAL SESSION
HOUSE OF DELEGATES

State Medical Society of Wisconsin
MAY 13, 14 and 15, 1968

Supplement to WISCONSIN MEDICAL JOURNAL
September 1968

TABLE OF CONTENTS

Reports and Proceedings of the 1968 Annual Session of the House of Delegates, State Medical Society of Wisconsin, May 13–15, 1968, Milwaukee

Report of Commission on Scientific Medicine 448

Report of Commission on Hospital Relations and Medical Education 450

Report of Council Committee on Military Medical Service 451

Report of Committee on Occupational Health of the Commission on Health Information 451

Report of Division on Maternal and Child Welfare of Commission on State Departments 452

Report of Division on Handicapped Children of Commission on State Departments 453

Report of Division on Chest Diseases of Commission on State Departments 453

Report of Commission on Medical Care Plans for the Year 1967 454

Report of Division on Ear, Nose and Throat 458

Report of Division on School Health 458

- Statement on School Health Service Aids 459
- Report to School on Significant Findings of Health Examinations 460

Report of Division on Alcoholism and Addiction 460

Report of Commission on Safe Transportation 461

Report of Division on Vision 463

Report of Commission on Public Policy 464

Report of Council 465

- Necrology Report 466
- Proposed Operating Budget—1968 467
- Membership Report 470

Supplementary Report of the Council 471

- Report on Request to Attorney General for Opinion on Nontherapeutic Sterilization 471
- Physician Guidelines for Highway Accident Blood Alcohol Testing 472

Report of Division on Nervous and Mental Diseases 473

Resolutions A, B, C, D, and E 475

Resolutions F, G, and H 476

Resolutions I, J, and K 477

Resolutions L, M, and N 478

Informational Report of Executive Committee of Board of Trustees: Charitable, Educational and Scientific Foundation 478

Report of President 481

Report of President-elect 482

Report of Secretary 483

Report of Treasurer 484

Consolidated Balance Sheet: December 31, 1967 484

Report of Woman's Auxiliary 493

- Supplementary Report of Woman's Auxiliary 493

Report of State Health Officer 495

Report of the State Medical Examining Board 496

Report of the Dean, University of Wisconsin Medical School 497

Report of the Dean, Marquette School of Medicine 498

Presentation of AMA–ERF Checks 498

Presentation of Certificates to Vietnam Volunteer Physicians 498

Presentation of John H. Houghton Medical Student Awards 498

Committee on Nominations 499

Report of Committee on Nominations 499

Election of Councilors 499

Remarks of Secretary 499

Committee on Credentials 499

Attendance at House of Delegates 500

Services to Physicians and the Public 502

List of State and County Medical Society Officers, Councilors, and AMA Delegates 503

Medical Memo: Museum of Medical Progress and Stovall Hall of Health 507

REPORTS AND PROCEEDINGS OF THE HOUSE OF DELEGATES AT THE ANNUAL SESSION

State Medical Society of Wisconsin May 13–15, 1968—Milwaukee

The annual session of the House of Delegates of the State Medical Society of Wisconsin was held at the Sheraton–Schroeder Hotel in Milwaukee, May 13–15, 1968.

Presented below are reports submitted to the House, the recommendations by reference committees, and the House actions on these reports.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

RUSSELL F. LEWIS, MD, Marshfield, Chairman
C. J. STRANG, MD, Barron
GEORGE W. DEAN, MD, Milwaukee
W. D. HAMLIN, MD, Mineral Point
MARVIN WRIGHT, MD, Rhinelander

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

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W. F. HENKEN, MD, Racine
C. E. KOEPP, MD, Marinette
J. F. KOVACIC, MD, Sheboygan
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F. E. GEHIN, MD, Stevens Point
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S. E. ZAWODNY, MD, Milwaukee
R. L. BEILMAN, MD, Madison
W. G. KENDELL, MD, Fond du Lac
G. B. MURPHY, JR. MD, La Crosse

■ PROCEEDINGS OF 1967 SESSION OF HOUSE

The entire proceedings of the May 1967 Annual Session of the House were printed in a supplement to the September 1967 issue of the *Wisconsin Medical Journal*, beginning at page 443.

HOUSE OF DELEGATES ACTION—Approved as printed.

Report No. 1

■ REPORT OF COMMISSION ON SCIENTIFIC MEDICINE—May 1968

THOMAS V. GEPPERT, MD, Madison, Chairman
OVID O. MEYER, MD, Madison
EDGAR S. GORDON, MD, Madison
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BEN R. LAWTON, MD, Marshfield
G. J. DERUS, MD, Madison
E. R. DANIELS, MD, Milwaukee
VICTOR S. FALK, JR., MD, Ex Officio, Edgerton
G. A. KERRIGAN, MD, Dean, Marquette Medical School, Ex Officio
P. L. EICHMAN, MD, Dean, University of Wisconsin Medical School, Ex Officio

Since its last report to the Council and the House of Delegates, the Commission on Scientific Medicine has held five meetings. The Commission recognizes the continuing trend in postgraduate medical education has brought into prominence the teaching programs of the specialty societies and the Academy of General Practice. It also notes the increasing role in postgraduate teaching of the Marquette School of Medicine and the University of Wisconsin Medical School.

This report will update those previously submitted and will set forth the activities of the Commission, so as not to overlap other reports submitted to the House of Delegates.

The Annual Meeting

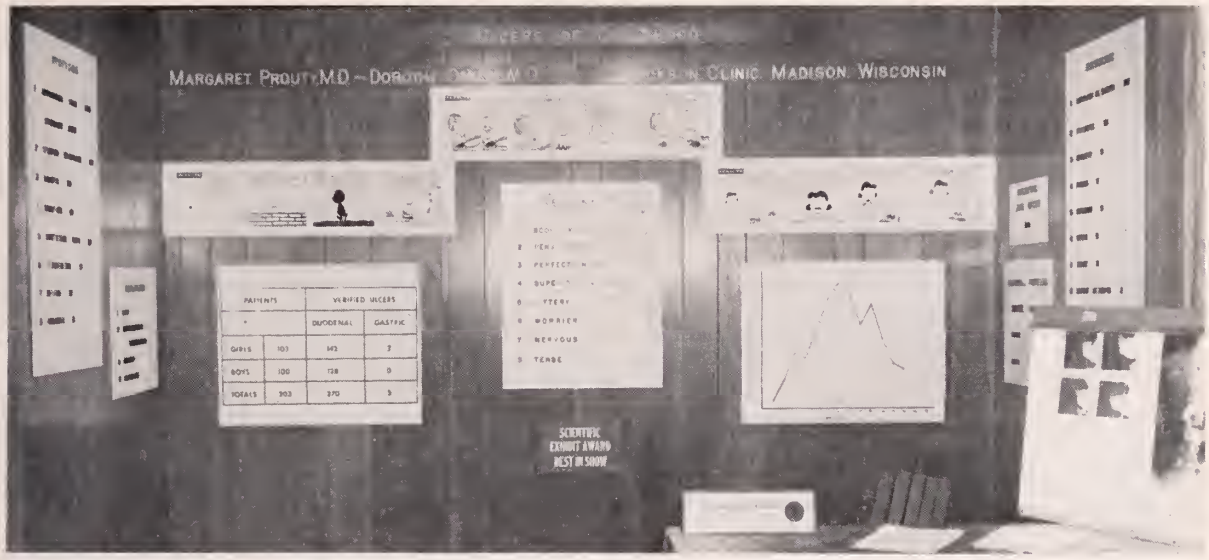
While an attempt was made to schedule all meetings of the House of Delegates and committees at times other than those during which the Scientific program and exhibits were scheduled, this was determined by the Council not to be completely feasible. Hence, the schedule of events follows the pattern established in previous years. The reason for the request is the Commission believes more physician attendance is required at Scientific presentations and at exhibitor booths. Without *reasonable physician* registration at the booths of the technical exhibitors, their interest in displaying their products, and educating physicians by personal contact, will wane. Should this happen to a marked degree, funds other than exhibit space rental would have to be found if the present format of the Annual Meeting is to continue or if, indeed, the Annual Meeting itself is to survive.

The Commission is aware of the financial dependence the Society has on its technical exhibitors whose rental of exhibit space at the Annual Meeting provides the *major source of income* to offset expenses. The Commission would like to present the thesis that a change in the format of the Annual Meeting be explored and replace exhibitor income with an appropriate registration fee for physicians who attend. This would enable the Society to hold its Annual Meeting without the necessity of providing 18,000 square feet of flat floor space for commercial exhibitors. It would allow other Wisconsin communities to be eligible to accommodate the Annual Meeting provided the other requirements for sleeping rooms, meeting facilities and luncheon facilities were available. The Commission is aware a registration fee of the amount required could seriously affect physician attendance. It would like to have the reaction of the House of Delegates to this consideration.

The program for 1968 has purposely followed no single theme. The specialty societies, which cooperated in planning the Annual Meeting, did so, keeping in mind the educational desires of not only their members, but also their colleagues in general practice. These programs have been planned with the purpose of giving the physician who attends some practical ideas which he can apply in his own practice, as well as to present new concepts and theories which are developing.

The Commission has not abandoned its consideration of presenting a "high-level" program on some special subject utilizing international authorities, but it has found that two or three years advance planning must be given to any such top level program.

However, this year the Commission is presenting, as a pilot first, an intensive day-long "Seminar on the Kidney." Attendance at this program was limited to 30 physicians, and a registration fee of



THE MEAD–JOHNSON AESCULAPIUS AWARD, which carries with it a beautifully framed plaque and a financial stipend, was given to Drs. Margaret Prouty and Dorothy W. Oakley of the Jackson Clinic in Madison for their scientific exhibit, "Ulcers in Childhood." This exhibit also was named "Best in the Show."

$25.00 was made. Reactions of those who attend will be solicited so that it can be determined whether to continue this type of special basic science program.

Associated Teaching Programs

For the fifth academic year, the State Medical Society, in cooperation with the University of Wisconsin Medical School and the Madison Chapter of the Wisconsin Academy of General Practice, has presented a series of four one-day In-Depth Conferences. The programs in 1967–1968 have covered the areas of marital problems, immunology and allergy, hypertension, and anticoagulants. While attendance has been steady and made up primarily of those physicians who have attended Conferences of previous years, it has not increased as anticipated. The Commission would like to reemphasize the educational value of these Conferences, and urge greater attendance. It is gratifying to note several members of the Wisconsin Osteopathic Association have been among the consistent attendees. It is anticipated the University will again assist with similar In-Depth programs in the coming years.

The State Medical Society has cooperated with the Division of Health in presenting four day-long Conferences on the subject "Care of the Newborn Infant" in four areas of the State. These programs have been planned for nurses in the A.M. and for physicians in the P.M. Much effort has gone into the content of these programs, and those who have attended have benefited accordingly.

The Division on Nervous and Mental Diseases again presented a scientific program on April 5, 1967, entitled "Symposium on the Geriatric Patient" in Eau Claire with a total attendance of 204 participants, most of whom were physicians. This was well received. The Commission was delighted to cooperate with the development of this program.

Speakers' Service

For the sixth consecutive year, the Speakers' Service to County Medical Societies has been continued. Through March, 27 speakers presented 27 programs to 14 county medical societies. This Service would not be possible were it not for the financial support of the Division of Health, American Cancer Society, Wisconsin Heart Association, and the Postgraduate Teaching Program of Merck Sharp and Dohme.

The Commission attempts to keep abreast of newly developing postgraduate programs in Wisconsin:

Postgraduate medical educational programs of the Wisconsin Regional Medical Program

University of Wisconsin teaching programs
- Direct-dial, toll-free medical lectures
- Live and direct telephone conference series
- Single concept medical films
- Slow scan TV programs

—and cooperates whenever possible.

Many changes continue to be made in the area of medical education and postgraduate instruction. The Commission stands ready to respond to all suggestions where it may better serve the educational needs of the membership of the Society, and will welcome such suggestions. It also wishes to cooperate with any other commissions or committees of the Society in assisting with program planning to meet the continuing postgraduate educational requirements of physicians.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Commended the Commission for its programming for the 1968 Annual Meeting, but encouraged the Commission to review the format of the meeting and the feasibility of charging a registration fee to physicians. It asked the Commission to report to the House on this subject at the 1969 Annual Meeting. Emphasized the availability of the Speakers Service provided by the Commission, and encouraged county societies to make further use of this service.

HOUSE OF DELEGATES ACTION—Accepted the report of the Commission on Scientific Medicine as recommended by the Reference Committee.

Report No. 2

■ REPORT OF COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION—May 1968

GEORGE B. MURPHY, JR., MD, La Crosse, Chairman
L. W. SCHRANK, MD, Waupun
A. J. RICHTSMEIER, MD, Madison
R. S. GALGANO, MD, Delavan
PAUL C. DIETZ, MD, La Crosse
S. L. HENKE, MD, Eau Claire
DONALD E. KOEPKE, MD, Milwaukee
DALE V. MOEN, MD, Shell Lake
GEORGE W. HILLIARD, MD, Milwaukee
PETER L. EICHMAN, MD, Ex Officio, Madison
GERALD A. KERRIGAN, MD, Ex Officio, Milwaukee

Since its last report to the Council and the House of Delegates, the Commission on Hospital Relations and Medical Education has met four times, and its Executive Committee has met once.

On March 11, 1967, the Council designated this Commission to act as the State Medical Society Liaison Committee with nurses and the nursing profession. The Commission has held several meetings with representatives of nursing, and has been instrumental in the formation of an Ad Hoc Committee on Nursing which has membership from The State Medical Society, the Wisconsin Hospital Association, the Division of Nursing, the Wisconsin Nurses Association, and other organizations which have a close affiliation with nursing.

The Commission believes, as a result of its continuing meetings with the nursing profession, areas of cooperation and understanding of each others' problems, goals, and responsibilities in the care of the sick are being more clearly defined. The Commission will continue this liaison assignment with nursing.

The Commission has worked closely with the Division on Safe Transportation in developing standards for Emergency Medical care. It has prepared an initial recommended classification of hospital emergency rooms as its part in developing Emergency Care Standards. It has sent a representative to each of the AMA sponsored Conferences on Emergency Medical Care, who has reported results to the Commission. The second such Conference held in January, 1968, indicated the matter was being given less importance than originally was conceived. However, the Commission believes strongly some imspection system should be established to classify hospital emergency rooms which would indicate to the public and to all providers of emergency service precisely the facilities for emergency care available in each.

A Town and Gown Symposium was presented at the Society building on March 23. The theme of the Symposium was, "Delivery of Medical Services and the Teaching of Medicine,"—Relating to the Use of Private Patients in Medical Teaching. An evaluation of this meeting will be included in a subsequent report.

The Commission reviewed the Proposed Rules of the Division of Health, Department of Health and Social Services Governing General and Special Hospitals, Chapter H 24. It contacted component county medical societies and the specialty societies whose involvement with in-hospital medical practice were affected. Following receipt of reactions of the various medical groups contacted, the Commission filed a letter with the Division of Health setting forth its areas of agreement and recommendations for change and modification to the Proposed Rules. It is expected the Rules will become part of the Administrative Code and carry the force of law when finally adopted.

Report of the Governor's Task Force on Medical Education

On January 5, the Governor released the report of his Task Force on Medical Education. The Task Force was composed of 16 private citizens (including two private practitioners and the Deans of the two Medical Schools) and four legislators.

The Commission believes the Report is of such far reaching interest to medicine, it herewith presents the Summary of Findings and Recommendations Section to the Council and House of Delegates for its information and reaction. (Printed in the May 1968 issue of the *Wisconsin Medical Journal* at page 276.)

Wisconsin Regional Medical Program, Inc.

On Sept. 1, 1967, the Wisconsin Regional Medical Program was given operational status and received funds for support of five operational projects in addition to funds for planning. The total grant for the period Sept. 1, 1967, to Aug. 31, 1968, is $319,458.00 for direct costs.

The operational projects now underway in the Wisconsin Regional Medical Program, Inc. are:

1. A study program for uterine cancer therapy and evaluation.
2. A demonstration program for pulmonary thromboembolism.
3. Dial access information service for physicians.
4. Dial access information service for nurses.
5. Single concept films in heart disease, cancer and stroke.

Study groups and committees of the Planning Committee of the Wisconsin Regional Medical Program, Inc. are:

- Cancer Study Group
- Heart Study Group
- Stroke Study Group
- Resource Study Group
- Measurement & Data Collection Committee
- Postgraduate Education Committee
- Nursing Advisory Committee

Altogether throughout the organizational structure of the Wisconsin Regional Medical Program, 71 physicians are serving on one or more committees or study groups.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Noted that the Commission is continuing its liaison with the nursing profession, and recommended that the Commission continue to develop such liaison and take whatever steps are possible, both legislatively and with the State Board of Nursing, to increase the availability of nurses. Commended the Commission for its presentation of the recent Town and Gown Symposium and suggested that such programs be continued in the future. Urged all delegates and alternates to carefully read the findings in the summary report of the Governor's Task Force on Medical Education. Noted that the Commisssion is considering the development of guidelines for classifying hospital emergency rooms to indicate to the public and to all providers of emergency service the facilities for emergency care available in each, and recommended that any such standards developed be forwarded to the Council for its review and approval prior to adoption.

HOUSE OF DELEGATES ACTION—Accepted the report of the Commission on Hospital Relations and Medical Education as recommended by the Reference Committee.

Report No. 3

REPORT OF COUNCIL COMMITTEE ON MILITARY MEDICAL SERVICE—May 1968

F. L. WESTON, MD, Madison, Chairman
D. S. ARVOLD, MD, Shawano
O. G. MOLAND, MD, Augusta
H. M. STEEN, MD, Oshkosh
J. M. SULLIVAN, MD, Milwaukee

Since its advent, the Council Committee on Military Medical Service has worked closely with the Wisconsin State Advisory Committee to Selective Service on Medical, Dental, Veterinarian, and other Specialists in making recommendations about the status of individual physicians practicing in Wisconsin.

While the criteria of Selective Service for drafting physicians to the Armed Forces has varied from year to year, standards adopted by the Council Committee on Military Medical Service have remained consistent.

Any recommendation made by the Committee is just that. The actual selection of a physician for active duty rests solely in the structure of his local draft board. This point is not always understood by physicians from whom a recommendation is solicited.

It should be made quite clear to the Council and the House of Delegates that the single most important evaluation made by the Committee is whether or not removal of the physician from his community will result in lowering the availability of essential health services to a point below minimum standards.

Another criterion used by the Committee in the evaluation of physicians engaged in residency programs is to recommend they be permitted to complete the residency if the physician, at the time of request for evaluation, is actually in his last year of residency.

Due to the increasing needs of the Armed Forces for medical personnel, it is anticipated the numbers of Wisconsin-registered physicians required for active duty will equal or exceed the numbers of previous years. And for this reason, the Committee on Military Medical Service wishes to submit this report of its established procedures when requested to submit a recommendation.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Suggested that the House review and emphasize to constituents that the Committee is empowered only to make recommendations, and that the actual selection of a physician for active duty rests solely in the discretion of his local draft board.

HOUSE OF DELEGATES ACTION—Accepted the report of the Committee on Military Medical Service as recommended by the Reference Committee.

Report No. 4

REPORT OF COMMITTEE ON OCCUPATIONAL HEALTH OF THE COMMISSION ON HEALTH INFORMATION—May 1968

JAMES M. WILKE, MD, Madison, Chairman
DONALD M. RUCH, MD, Milwaukee
J. V. FLANNERY, MD, Wausau
OTTO T. MALLERY, MD, Wausau
CARL ZENZ, MD, West Allis
LOUIS OLSMAN, MD, Kenosha
ALLEN G. BRAILEY, MD, La Crosse
WILLIAM W. FORD, MD, Green Bay

The Committee on Occupational Health has been active in several areas since its last report to the House of Delegates, and is pleased to submit this report outlining its functions.

Occupational Health Guide

Since the original publication of this valuable Guide, the Committee has distributed more than 700 copies. A second printing was made during the summer of 1967 in order to meet the request for copies. This endeavor has been financially self-supporting, so no Society funds were utilized in preparation and distribution. The Guide continues to be available to medical and nursing personnel engaged in occupational health programs.

Migrant Labor

The Committee continues to watch with interest the assignment of sanitary inspection of migrant labor camps to the Industrial Commission. It also understands eligible migrant workers will receive benefits under Title XIX for health services.

Industrial Health Clinics

The Committee sponsored and presented a Workshop, "Employee Health in Industry," on Oct. 13, 1967, in Wausau. This was presented primarily for the smaller industrial operations in Wisconsin to encourage those companies which did not have employee health programs to consider establishing one. The Conference was attended by 74 interested persons. The analysis made proved it to be highly successful.

The Committee also cosponsored a Conference on Hospital Employee Health Programs in Milwaukee on November 30. More than 75 hospital and medical personnel attended.

The Committee had planned a spring conference on Pesticides and Insecticides to be held in Racine. However, due to the untimely loss of Dr. Robert S. Wright, this conference has been postponed.

The Committee wishes to pay tribute to the late Doctor Wright for his untiring contributions to its efforts.

The Committee notes with interest the development of the American Medical Association's Registry on Adverse Reactions Due to Occupational Exposures. The purpose of this Registry is to obtain information not previously reported in the literature —adverse effects from exposures to new chemicals, biological or physical agents, or adverse effects from exposures to old materials used in new processes. The identity of cases and physicians will be held confidential. Only conclusions from the evaluation and analysis of the reports will be published.

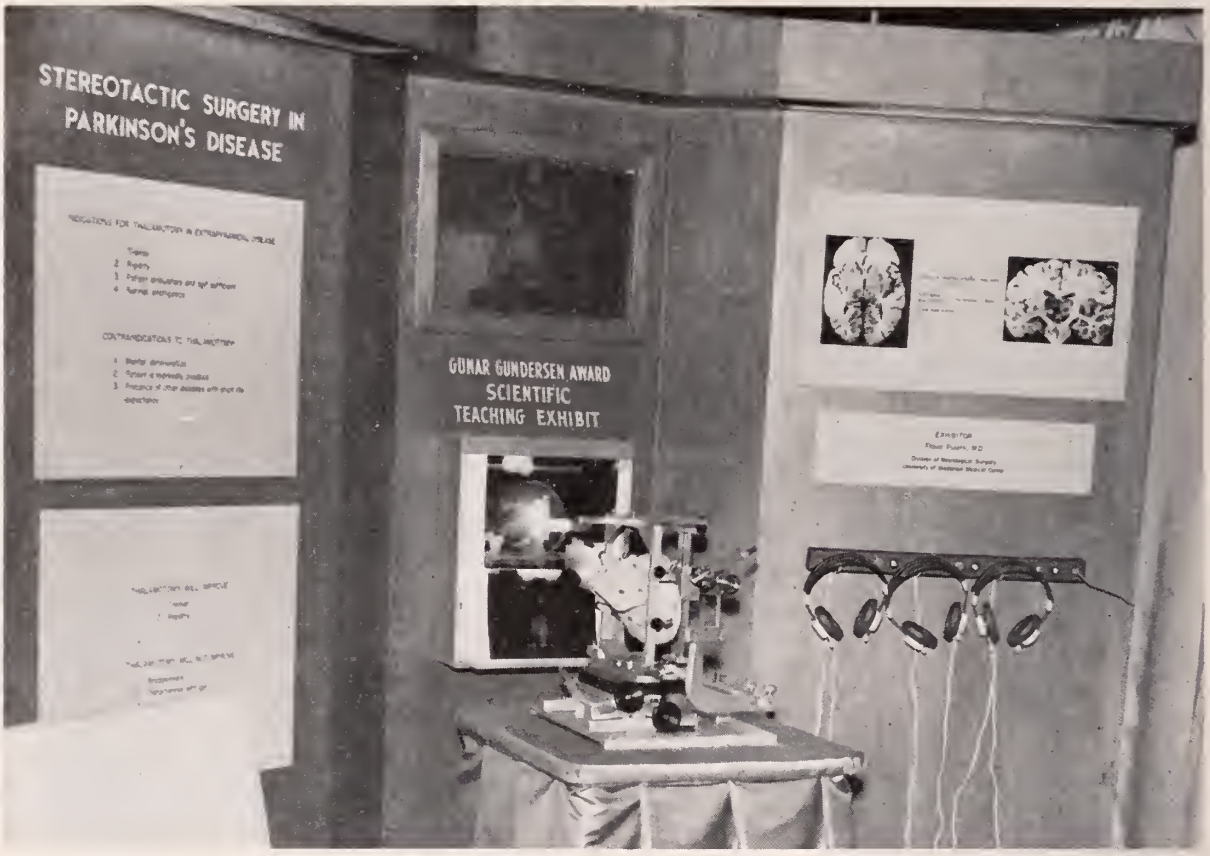
The Committee was privileged to be represented at the 27th Annual Congress on Occupational Health held in Atlanta in September. Many favorable comments were expressed relating to the Occupational Health Guide at this meeting.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended that the Committee continue to sponsor industrial health clinics, and further recommended that the Committee, as previously planned, sponsor a Conference on Pesticides and Insecticides in the near future.

HOUSE OF DELEGATES ACTION—Accepted the report of the Committee on Occupational Health as recommended by the Reference Committee.

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.



GUNDERSEN AWARD—The Gunnar Gundersen Award for the best scientific teaching exhibit was presented to Dr. Flavio Puletti of the Division of Neurological Surgery, University of Wisconsin Medical School, Madison, for his exhibit entitled "Stereotactic Surgery in Parkinson's Disease."

Report No. 5

REPORT OF DIVISION ON MATERNAL AND CHILD WELFARE OF COMMISSION ON STATE DEPARTMENTS—May 1968

JOHN R. EVRARD, MD, Milwaukee, Chairman
RICHARD C. BROWN, MD, Eau Claire
N. M. HILRICH, MD, Milwaukee
WILLIAM R. KREUL, MD, Racine
T. A. LEONARD, MD, Madison
B. P. WALDKIRCH, MD, De Pere
E. A. BIRGE, MD, Wauwatosa
STANLEY N. GRAVEN, MD, Madison
STEWART L. GRIGGS, MD, Green Bay
K. J. WINTERS, MD, Wauwatosa
F. G. JOHNSON, MD, Superior
MERLIN J. OLSON, MD, Monroe
KENNETH F. PELANT, MD, Grafton
GEORGE H. STEVENS, MD, Wausau

Since its last report to the House of Delegates in May 1967, the Division has held two meetings.

It has engaged in cosponsorship of Care of the Newborn and Premature Infant Institutes at the following locations:

November 1, 1967 _____Neenah, Wisconsin
November 2, 1967 _____Tomahawk, Wisconsin
January 24, 1968 _____Waukesha, Wisconsin
March 14, 1968 _____Dodgeville, Wisconsin

The Division continues to be most interested in the overall problems of the Care of the Premature Infant, and believes much more scientific knowledge will be gained and be made available to the practicing physician as the several research programs in this field produce results. The Division will continue its efforts in this field and will report periodically to the House of Delegates.

The Division was represented at the First International Conference on Prematurity in January. A subsequent report will be made to the Division which will update its thinking and may affect future educational programs offered.

The Division has been engaged in studying maternal care and has appointed a subcommittee to try to arrive at a precise, all-inclusive definition of maternal care.

The Division has surveyed all of the hospitals in Wisconsin relative to the availability of blood and fibrinogen.

In the fibrinogen survey, each hospital was asked to indicate:

Number of units
Expiration date
Lot numbers
Can fibrinogen be obtained elsewhere?
Name of source

Of the 163 hospitals which responded to the questionnaire, 28 stated they had no fibrinogen on hand, 6 were located in Milwaukee County and indicated fibrinogen was available from the Milwaukee Blood Center. Two hospitals have discontinued obstetrical service and had no fibrinogen on hand. The other 20 hospitals indicated none was on hand. These, for the most part, are located in smaller towns in rural

areas. Ten of these indicated a source of fibrinogen, and ten indicated no source.

The Division also conducted a survey among the hospitals as to the availability of blood for obstetrical emergencies.

Of the 161 hospitals offering obstetrical care, which responded to this questionnarie, all but three hospitals had either an arrangement with a blood bank or used local donors. Transportation of blood was arranged with the cooperation of sheriffs and State Patrol facilities in the hospitals which utilize regional blood centers.

The Division is concerned that each hospital with an obstetrical department has *on hand* a current supply of fibrinogen and, in addition, has whole, fresh blood available for patients with the least possible time lag between supply and administration. The Division believes that in the mechanism of the survey it has emphasized the importance of on-hand fibrinogen and blood.

The Division hopes to be instrumental in effecting a continuing supply of tested and current fibrinogen with the cooperation of the Division of Health and a supplier of fibrinogen.

The Maternal Mortality Study Committee has reviewed maternal deaths which have been reported to it. It makes a plea to physicians, in completing death certificates, to indicate pregnancy or postpartum condition which may be present at the time of death.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Commended the Division for its efforts to date, including the co-sponsorship of Care of the Newborn and Premature Infant Institutes, and encouraged further involvement.

HOUSE OF DELEGATES ACTION—Accepted the report of the Division on Maternal and Child Welfare as recommended by the Reference Committee.

Report No. 6

■ REPORT OF DIVISION ON HANDICAPPED CHILDREN OF COMMISSION ON STATE DEPARTMENTS—May 1968

JOHN J. SUITS, MD, Marshfield, Chairman
ROBIN ALLIN, MD, Madison
BETTY BAMFORTH, MD, Madison
MAXINE BENNETT, MD, Madison
FRANK BERNARD, MD, Madison
MATTHEW D. DAVIS, MD, Madison
RICHARD E. JENSEN, MD, Green Bay
JAMES E. MILLER, MD, Madison
RAY R. RUECKERT, MD, Portage
ARTHUR A. SIEBENS, MD, Madison
LLOYD P. WILLIAMS, MD, Appleton

The Division on Handicapped Children functions primarily as an advisory committee to the Medical Director of the Bureau for Handicapped Children of the Wisconsin Department of Public Instruction.

The Division has recently had the opportunity of a complete review of the medical functions and services of the Bureau for Handicapped Children. Some of the major points covered in this review were:

1. Case Finding—the mechanism of determining which children are candidates for Bureau services.
2. Diagnostic Services—orthopedic and otologic field clinics. This discussion features the otomobile, a self-contained hearing testing laboratory mounted in a bus.

   NOTE: The otomobile was on display as a scientific exhibit at the Auditorium loading area on State Street during this annual meeting. Members of the House of Delegates were urged to visit this exhibit and to acquaint themselves with its features.
3. Interim Diagnostic Examinations authorized between scheduled field clinics.
4. Physician Eligibility for Reimbursement—Current rules limit physicians eligible to participate in the programs to those who are members of their American Specialty Board. A plea was made to also include those physicians who are Board eligible but because of time-in-practice requirement have not taken certifying examinations.
5. Orthopedic Schools—twelve in number throughout the state. Amputee program and costs of prosthetics was discussed.
6. Cleft Palate Clinic—one is in Madison, the other in Milwaukee.
7. Hearing Conservation—more attention should be given to the pre-school age child who evidences hearing abnormalities. Presently the child may not be seen until he reaches school age and several very valuable years are lost for diagnosis and treatment procedures.
8. Other services are listed:
   - Cardiac Program
   - Cystic Fibrosis treatment and annual check-up
   - Orthodontia
   - Special education series to the blind and visually handicapped
   - Records kept and reports made
   - In-service training for parents and professionals

Periodic conferences of physicians are held (first in February of this year) to determine unmet needs in the care of the handicapped child.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Commended the Division's efforts and encouraged their continuance. Noted that the Minnesota program on hearing conservation is aimed at the pre-school aged children and is effected through community involvement. It recommended that that program be studied in further depth and evaluated for possible adaptation in Wisconsin.

HOUSE OF DELEGATES ACTION—Accepted the report of the Division on Handicapped Children as recommended by the Reference Committee.

Report No. 7

■ REPORT OF DIVISION ON CHEST DISEASES OF COMMISSION ON STATE DEPARTMENTS—May 1968

H. A. ANDERSON, MD, Stevens Point, Chairman
JOHN H. HUSTON, MD, Milwaukee
LOUIS G. NEZWORSKI, MD, Eau Claire
DOUGLAS A. GUTHEIL, MD, De Pere
A. H. PEMBERTON, MD, Milwaukee
BEN R. LAWTON, MD, Marshfield
W. J. LITTLE, MD, Racine
JOHN RANKIN, MD, Madison
RICHARD A. ECKBERG, MD, Stevens Point

The Division on Chest Diseases wishes to report to the House of Delegates a cooperative venture which will be proposed to the Wisconsin Regional Medical Program Committee on Postgraduate Education to provide Heart-Chest Circuit Teaching Programs for physicians. The Wisconsin Regional Medical Program has in its structure a Heart Study Group as well as a Postgraduate Education Committee. The Division stands ready to cooperate fully

BEAUMONT MEMORIAL LECTURE—Dr. L. C. Pomainville, right, of Wisconsin Rapids presented the William Beaumont Memorial Award to Dr. John S. Najarian of Minneapolis after Doctor Najarian spoke on "The Current Status of Tissue Transplantation." He is professor and chairman of the Department of Surgery, University of Minnesota School of Medicine. Doctor Pomainville is the State Medical Society historian and a trustee of the Charitable, Educational and Scientific Foundation which administers the Beaumont Memorial Fund.

with the Committee of the Regional Medical Program in bringing to Wisconsin physicians postgraduate programs on heart-chest diseases.

The Division made available to each county medical society a pamphlet which indicated services offered by tuberculosis outpatient clinics in Wisconsin and encouraged dissemination of this information to the membership of county medical societies.

The Division wishes to bring to the attention of the House of Delegates the fact that INH is available through the Division of Health at no cost to patients who are selected for its administration. The Division of Health, in addition, is recommending programs of screening for tuberculosis in the schools. Where a positive reactor is discovered, the family physician is notified and is encouraged to undertake proper treatment and laboratory procedures.

The Division also, through a communication to each county medical society, offered a program to provide a speaker on the subject of Chemoprophylaxis to the county medical society.

It is encouraging to note that county societies have responded to this invitation and, as of this date, five county societies have been visited and have received programs on Chemoprophylaxis, and it is anticipated additional requests for this program will be received.

During a recent meeting, the representatives of the Division of Health described a pilot program being suggested, to be held in Milwaukee. Two hospitals would be selected in which a full-time nurse would be assigned to conduct a tuberculin testing program for all patients admitted, to measure the result thereof, and to follow through with the attending physician on x-ray, laboratory work and chemoprophylaxis, if indicated, to be initiated while the patient is in the hospital. This program has not been undertaken, but is proposed; and this subject is furnished to the House of Delegates for its information.

The Division is interested in the problem of Emphysema in Wisconsin, and hopes the Division of Health will provide the information on the feasibility of an area-wide pilot study for the problem, and propose a program.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Noted that the Division's report was primarily one of information and recommended its acceptance.

HOUSE OF DELEGATES ACTION—Accepted the report of the Division on Chest Diseases.

Report No. 8

REPORT OF THE COMMISSION ON MEDICAL CARE PLANS FOR THE YEAR 1967—March 1968

E. M. DESSLOCH, MD, Prairie du Chien, Chairman
ROBERT KROHN, MD, Black River Falls, Vice-chairman
W. T. CASPER, MD, Milwaukee
A. J. McCAREY, MD, Green Bay
J. T. SPRAGUE, MD, Madison
F. H. WOLF, MD, La Crosse
CHARLES BENKENDORF, MD, Green Bay
T. J. DOYLE, MD, Superior
MILTON FINN, MD, Superior
D. A. JEFFRIES, MD, Shawano
R. A. SIEVERT, MD, Madison
W. E. WRIGHT, MD, Mondovi
G. W. CARLSON, MD, Appleton
D. N. GOLDSTEIN, MD, Kenosha
A. W. HILKER, MD, Eau Claire
P. B. MASON, MD, Sheboygan
HOWARD MAUTHE, MD, Fond du Lac
E. J. NORDBY, MD, Madison
L. O. SIMENSTAD, MD, Osceola
A. H. STAHMER, MD, Wausau

Some matters follow to which the CMCP directed its attention during 1967 and which will be the subject of further study in 1968.

There is an ever-increasing demand from employers and others for varied insurance coverages. It is one of the responsibilities of Blue Shield to continually consider the adequacy of available programs and lead the way in designing additional coverage areas best suited to the patient's need. To meet this responsibility the CMCP has under constant study a review of present programs and the areas in which the buyer should have improved prepaid health benefits within a reasonable cost level.

* * *

Many current publications carry articles on the subject of "medical costs," and changes in these costs, both in the past and projected into the future. As the public seeks and receives increased medical care and with the advent of expanded coverage through government programs, patients, government, and insurers are expressing greater interest in so-called "control of rising medical costs." The medical profession is looked to for leadership in this area. The CMCP and other committees of the medical society must be a part of future developments in this area.

* * *

In July, 1967, the Wisconsin Legislature passed a bill to include podiatrists in all health insurance contracts. This law requires that the services of podiatrists must be paid if a benefit for care of the feet is included within the contract and such care would be covered when treatment was provided by a physician. WPS was represented and heard, but not heeded, during public hearings on the bill during which the added costs and the uneven geographic distribution of podiatrists were pointed out.

Legislative action which expands insurance benefits and directs to whom they will be paid can set a precedent for government control of the public's choice of insurance protection. The insured is subjected without choice to the resulting claim experience and rate results, when in fact he often cannot avail himself of the services either by choice or because a provider of the services does not exist in his geographic area.

Providers of services may have experienced some delays in receipt of payment for claims submitted under the Wisconsin Medical Assistance Program (Title XIX). The main cause of these delays lies in the traditional method of county certification and recertification for numerous, usually consecutive, short periods of eligibility. Frequent changes to the master certification records result in delaying claims processing until all updating is completed.

The Wisconsin Department of Health and Social Services along with its sub-contractors is implementing a revision of the method of certification. By certifying a recipient as eligible until eligibility is cancelled, the time-consuming task involved in recertification will be reduced.

Medical Assistance recipients over 65 who are also entitled to Federal Medicare benefits create circumstances of unavoidable delay in provider reimbursement. The Medical Assistance Program may not reimburse until Federal Medicare liability is determined. Thus, until a Medicare Part B form is filed, processing must be held on the Medical Assistance claim.

* * *

The CMCP has suggested to the Council that it pursue the question of current mechanisms used in establishing rulings under government programs. The CMCP has some concern that under the government-sponsored programs the possibility exists that rulings inconsistent with the best interests of the patient and provider of care can be established by interpretation at the governmental administration level. Although governmental programs are a current fact of life, their administration calls for active participation by the medical profession. In its role as carrier under two such programs, WPS attempts to watch carefully and take issue on all rulings inconsistent with the patient's interest and those from whom they receive health care.

* * *

The following report on WPS operations includes highlights of 1967's financial picture, enrollment activities, claims processing, administrative functions, communications, NABSP activities, and administration of government programs.

Financial

Total income of WPS during 1967 increased $3,753,164 over 1966.

Earned Premium	$22,866,176
Investment and Other Income	494,558
	$23,360,734

Subscriber benefits incurred amounted to $19,670,303—almost 3 million dollars greater than 1966. In 1967 benefits paid to subscribers represented about 86¢ of each premium dollar.

The operating expense for the year was $2,576,279, 11.27% of earned premium. This was consistent with approved administrative budgets. Net operating income of $619,594 added to the investment income of $494,558 produced an addition of $1,114,152 to reserves.

The WPS balance sheet on December 31, 1967, reflects total assets of $14,547,604 and general reserves of $5,649,515. This is believed currently adequate to assure the financial stability of WPS.

Enrollment

Sizeable growth occurred in WPS enrollment during 1967 as evidenced by the 1966–67 enrollment comparison included in this report. The increase obtained was primarily the result of writing new groups in the 10 to 200 employee size category and increased nongroup enrollment.

Gains were obtained in each coverage category, reflecting a well-balanced marketing effort.

The strong growth pattern of WPS was recognized by NABSP through its award to WPS for achieving the largest net gain in enrollment in the WPS plan size class during the twelve-month period ending in June, 1967.

The following 1966–67 comparison reveals the net enrollment growth obtained during 1967.

	Enrollment Dec. 31, 1966	Enrollment Dec. 31, 1967	Net Gain
Surgical-Medical Contracts			
Group	114,701	128,929	14,228
Nongroup	9,595	12,971	3,376
Conversion	4,756	5,045	289
Medicare-PLUS $15,000 (Over 65)	31,557	35,852	4,295
TOTAL	160,609	182,797	22,188
Hospital Contracts			
Group	51,603	62,555	10,952
Nongroup	8,648	12,181	3,533
Conversion	2,891	3,114	223
Medicare-PLUS $15,000 (Over 65)	29,249	33,199	3,950
TOTAL	92,391	111,049	18,658
Major Medical Contracts			
Group	49,404	64,885	15,481
Medicare-PLUS $15,000 (Over 65)	31,211	35,591	4,380
TOTAL	80,615	100,476	19,861

It is estimated WPS-covered persons (includes all family members) now total 473,000.

ENROLLMENT ACTIVITIES: WPS continued to promote the sale of outpatient diagnostic and laboratory coverage so that the patient has this benefit available when not hospitalized. During the year this benefit was added to the coverage of 8,203 existing contracts. The benefit was also sold to 5,924 new contract holders. This brings DXL coverage to an estimated 35,000 additional individuals in 1967.

An open enrollment for the WPS Medicare-PLUS $15,000 contract was held during the last quarter of 1967. Slightly in excess of 35,000 people over age 65 are currently covered under this contract.

Within the past few years a new mass sales marketing technique has been developed to provide health coverage to bank depositors. This concept permits premium collection stability by virtue of subscriber-authorized bank account premium withdrawals as premiums become due. WPS has actively entered this field during the past year.

A primary sales manpower goal during the year was the continued sales training and development of new salesmen employed the latter part of 1966 and during 1967. Sales representation that will properly reflect the philosophy of the profession is a prominent training objective.

Service, the primary function WPS can perform for subscribers, has required that service representative positions be established to provide prompt field service liaison to group employer locations. Routine service calls on coverage and administrative questions assist the buyer in bringing his employees the best in prepaid health care benefits. The service assignment to specific individuals also enables group

sales representatives to devote more time to sales activity.

MARKET TRENDS: The increasing tendency of management and labor to negotiate health coverage benefits results in an ever-increasing demand for benefit flexibility. While in some cases this requires special benefit design, the increasing interest in the customary, usual and reasonable fee concept places WPS in an advantageous position.

Today's group insurance buyer is knowledgeable. He wants broad coverage, prompt and efficient service, timely comprehensive claims experience information and the overall knowledge that his premium dollar is well spent. Fulfilling this obligation is a continuing challenge.

WPS Claims

A total of 320,600 WPS claims resulted in payment of $19,670,303 in 1967. The average claim payment in 1967 was approximately $62 compared to an average payment of $74 in 1966. This change in pattern results from an increase in the number of claims with a small dollar value, largely the result of (1) sale of Diagnostic, X-ray and Laboratory coverage during the past year, (2) increased independent billing by hospital-based physicians, and (3) payment of claims covering Title XVIII's deductible and coinsurance under the Medicare-PLUS $15,000 contract.

Administrative

Employees assigned to the various WPS functions, including the government programs which WPS administers, numbered 571 at year end.

Late in the year Underwriting, Billing, WPS Claims and Home Office Sales were moved into the new leased building on Olin Avenue (about six blocks from the home office). At the same time, Computer Services keypunch personnel and equipment were moved to the East Lakeside Annex next to the Home Office.

Medicare and Title XIX claims remain in the Smithback Building on the East Beltline. With the WPS executive offices and the balance of WPS functions housed at the East Lakeside Home Office, operations are distributed between *four* locations. Although these locations are comparatively close to each other, the problems in workflow, transportation and communications present a constant challenge.

Total claims (WPS, Title XVIII, Title XIX and CHAMPUS) processed during 1967 were approximately two million in number for a total of nearly $48,600,000.

In July, 1966, at the inception of the government programs, WPS processed approximately 21,000 WPS claims. One million dollars was disbursed.

In January, 1968, WPS processed approximately 227,000 claims. (Includes Goverment Programs and WPS claims). Six million dollars was disbursed.

Claim volumes are a tool in the measurement of WPS's total operational workload.

Communications

During 1967, the WPS advertising effort was distributed between three types of audiences. One was special purpose advertising, such as the Medicare-PLUS $15,000 Open Enrollment campaign; another was institutional, in the publications to specialized WPS markets; and a third was general purpose advertising. This third type was placed in newspapers, magazines with Wisconsin editions, and radio. Themes stressed were those of WPS as a progressive benefit innovator, and of the advantages of WPS benefits in young-adult family situations.

A new visual system of presenting WPS benefits, associated directly with the needs which those benefits fulfill, was developed for group sales during 1967. Designed to self-organize a benefit presentation, the new system features the unique facets of WPS benefits.

Distinctive colors and symbols were selected to identify each government-financed program administered by WPS. These themes have been continued throughout the manuals, bulletins and other educational material sent to physicians and others during 1967. It is hoped that these themes have helped simplify identification, filing and subsequent reference for physicians' offices, as they have in the WPS home office.

District X Meeting

On October 7–8, 1967, WPS was host to District X Blue Shield Plans from North Dakota, South Dakota, Nebraska, Wisconsin, Minnesota and Iowa. The emphasis of the conference concerned administrative progress of the Title XVIII and Title XIX programs, and because of the wide interest in this subject, an invitation was extended to related Blue Cross Plans, and federal and state personnel concerned with the administration of these programs.

Speakers from the State Medical Society of Wisconsin, the Department of Health, Education and Welfare, BCA, NABSP and the Wisconsin Department of Health and Social Services were on the program.

The meeting was well attended; and from comments by attendees, the program was well received.

On the National Scene

The National Blue Shield Board, at their August, 1967, meeting, adopted a resolution "to recommend the adoption of usual, customary and reasonable benefits by all (Blue Shield) Plans for National Account programming." This seems to complete the transition from the traditional "fee schedule," "income limit" and "participating physician" via "prevailing fees" to the position supported by WPS for fourteen years.

Also at the August meeting, the National Blue Shield Board encouraged Blue Shield Plans to take an active part in the development of drug coverage programs. It was further urged that programs developed include dispensing physicians. Drug coverage is one of the benefit demands the UAW obtained in their negotiations with Automakers. WPS has offered drug coverage since 1964.

Membership standards of National Blue Shield were altered during the April, 1967, business meeting. The change affected the requirement of "Medical Society Approval" by providing as an *acceptable alternate*, "participating agreements with a majority of the actively-practicing physicians in the Plan's area." A resolution was introduced and passed at the November 26–29, 1967, *AMA Annual Meeting* requesting National Blue Shield to rescind the change. National Blue Shield has since advised the AMA that their request will be given due consideration.

Medicare Part B—Title XVIII

Prior to January, 1967, the Medicare Part B Department was in its infancy. The volume of claims received was insignificant. Employees were new, largely part time, inexperienced and untrained. Physical facilities were limited.

The year 1967 brought a deluge of claims and Federal regulations. Faced with a substantial volume of incoming claims, efforts were directed toward the development of additional staff and computer services.

Almost 642,000 claims were received in 1967, billing Part B for 22 million dollars. These claims were processed to a result of 333,000 checks for 14.5 million dollars and 181,000 notifications of non-payment

INTERSTATE POSTGRADUATE TEACHING AWARD—Paul F. Clark, PhD, right, received the Interstate Postgraduate Medical Association's Teaching Award from Dr. Nels A. Hill of Madison. Doctor Clark is a prominent bacteriologist and teacher who has been associated with the University of Wisconsin Medical School since 1914. His laboratory studies have been chiefly in the field of virus disease of the central nervous system, especially poliomyelitis.

of 7.5 million dollars, most of which was applied to Medicare's deductible and coinsurance requirements.

During the course of this year, Title XVIII was subjected to a financial audit by the Social Security Administration (SSA) of the first six months under the Program. No major criticisms resulted. In addition, satisfactory spot reviews were carried out by SSA personnel in specific functions such as administration of usual, customary and reasonable fees, coding of claims and response to inquiries.

Wisconsin Medical Assistance Program—Title XIX

An average of 80,000 claims were processed each month amounting to approximately 1 million claims for 14 million dollars in total payments during 1967.

The number of certified recipients appears to be expanding under the Program with approximately 200,000 individuals certified at year end.

In 1967 Title XIX assigned staff continued to improve their performance aided by additional training, experience and computer services.

WPS administration of Title XIX for the first six months of the Program was subjected to a fiscal audit by the Department of Health and Social Services during 1967. There were no major criticisms.

Civilian Health and Medical Program of the Uniformed Services

WPS received about 527 claims per month during 1967 resulting in an average monthly payment of $49,500. This is an increase over 1966's monthly average of 426 claims for $32,900.

In addition to administration of CHAMPUS for Wisconsin, WPS subcontracted portions of the CHAMPUS administration for the states of Minnesota, Iowa, Indiana, North and South Dakota. Including these states, a total of 25,000 claims were processed for $1,850,000 during 1967.

Major changes occurred in the Program during the calendar year 1967.

On January 1, 1967, the Program was expanded to include retirees and their dependents—subject to deductibles for outpatient services and coinsurance for all claims.

On September 1, 1967, the Wisconsin carrier contract was reviewed and renewed for administration on the basis of customary, usual and reasonable fees.

Drug benefits were instituted in October, 1967.

Summary

WPS, the Doctors Plan of the State Medical Society, has shown sufficient continuous growth to provide a base for ongoing development of expanded health care benefits for Wisconsin residents.

Financial status is more than acceptable. The plan is in "good health." The cooperation of the entire profession in bringing the plan to a successful twenty-second year of operation is commendable. The Commission on Medical Care Plans also wishes to express its thanks to the Council for its assistance and guidance during the year.

Below is a condensed Balance Sheet and Operating Statement, both of which were prepared prior to the 1967 audit.

* * *

The attention of the Council is invited to the fact that three devoted members of the Commission passed away since last year's annual meeting. Doctors John Houghton, Wisconsin Dells; Robert Moore, Frederic, and Milton Davis, Milton, provided many hours of service to the Commission, and we shall miss greatly their advice and counsel.

WPS OPERATIONS REPORT

December 1967

	Year of 1967	% of Premium
Condensed Statement of Income and Expense		
Earned Premium—Net	$22,866,176	100.00
Benefits Incurred	19,670,303	86.02
Available for Operations and Reserves	$ 3,195,873	13.98
Operating Expenses	2,576,279	11.27
Net Operating Income	$ 619,594	2.71
Investment and Other Income—Net	494,558	2.16
Added to Reserves	$ 1,114,152	4.87
Condensed Balance Sheet—December 31, 1967		
What We Own:		
Cash	$ 90,952	
Receivables	1,682,402	
Securities—Bonds at Book; Stocks at Market	11,646,163	
Fixed Assets—Net	919,496	
All Other Assets	208,591	
TOTAL PROPERTIES	$14,547,604	
What We Owe:		
Accounts Payable	$ 250,191	
For Unreported and Unpaid Claims	5,632,765	
Unearned Premiums	2,940,436	
All Other Liabilities	74,697	
TOTAL OBLIGATIONS	$ 8,898,089	
TOTAL RESERVES	$ 5,649,515	

(This statement was prepared prior to the Annual Audit.)

RECOMMENDATION OF REFERENCE COMMITTEE ON FINANCES—Commended members of the Commission on Medical Care Plans and staff for their time and efforts in the direction of WPS and its related health care programs, noting the impressive growth and satisfactory financial condition of WPS as set forth in its report.

HOUSE OF DELEGATES ACTION—Accepted the report of the Commission on Medical Care Plans as recommended by the Reference Committee.

Report No. 9

REPORT OF DIVISION ON EAR, NOSE AND THROAT—May 1968

MEYER S. FOX, MD, Milwaukee, Chairman
W. B. LARKIN, MD, Eau Claire
PASCHAL SCIARRA, MD, Sheboygan
MAXINE BENNETT, MD, Madison
L. G. EBY, MD, Milwaukee
RICHARD H. BRODHEAD, MD, Wausau
R. D. LANGE, MD, Madison

The House of Delegates in May 1967 separated the Division on Visual and Hearing Defects into two divisions and the newly created Division on Ear, Nose and Throat has had several meetings since last May.

The majority of the meetings were called to consider a proposal of the Hearing Aid Dealers Association to create state licensure for hearing aid salesmen. In discussions concerning this legislation the Division met with representatives of the Department of Health and Social Services of the State of Wisconsin, the State Board of Medical Examiners, the Wisconsin Audiological Conference, the Wisconsin Otolaryngological Society, the Section on Otolaryngology of the State Medical Society, the Bureau for Handicapped Children, State Department of Public Instruction and the National Hearing Aid Industry Conference.

Out of the several meetings held with these groups the Division in cooperation with the Commission on Public Policy agreed to support a bill for hearing aid licensure, if the hearing aid dealers would agree to amend their legislation to provide for:

(a) A prohibition on selling or fitting a hearing aid to any person who has not at some prior time had a medical examination and evaluation for hearing loss.
(b) A prohibition on the sale of a hearing aid without proper audiological or otolaryngological evaluation.

These are but two of the conditions that the Division felt were desirable before the Society should support such legislation. The protection of the health and welfare of the hearing aid buying public far exceeds the importance of the desire for licensure by dealers and if this tantamount interest of the public is not guaranteed, then the Division recommends that such legislation be opposed in the future. If, however, in this or any other legislative sessions, bills are introduced to license hearing aid dealers which take into consideration the need for proper hearing examination and evaluation to protect the public, then the Division recommends tentative Society support as given during this past year.

In addition to hearing aid licensure, the Division also considered legislation which as introduced, would have set unrealistic limits on operator's license requirements for the hard of hearing driver. The Commission on Public Policy upon recommendation of the Division, sought amendments to this legislation.

In the area of government medical programs, the Division considered reimbursement and required authorization for hearing aids under Title XIX of P. L. 89–97. At present, Title XIX pays for transportation, hearing tests, hearing aids, batteries and upkeep. It is the recommendation of the Division that prior to prescribing, fitting or replacing a hearing aid, an individual should have a reliable and valid otological and audiological examination and evaluation by competent personnel. The Division has expressed its willingness to assist the State Department of Health and Social Services in drafting forms to record the results of otological and audiological tests, and if then the need presents itself, will do this within the next year.

The Division still will be considering plans for implementing a series of instruction courses for audiometric technique as previously approved by the House of Delegates. In addition to this program, it is hoped that a program limited to hearing conservation in industry will be able to be presented in the near future.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Noted that the Division was reporting as a separate division for the first time, and that its report indicated that the House can anticipate a program on hearing conservation in industry which will be welcomed.

HOUSE OF DELEGATES ACTION—Accepted the report of the Division on Ear, Nose, and Throat as recommended by the Reference Committee.

Report No. 10

REPORT OF DIVISION ON SCHOOL HEALTH—May 1968

JAMES C. H. RUSSELL, MD, Fort Atkinson, Chairman
MELVIN G. APELL, MD, Oshkosh
R. F. POSER, MD, Columbus
F. W. REICHARDT, MD, Stevens Point
ALLAN J. RYAN, MD, Madison
HORACE K. TENNEY, III, MD, Madison
WILLIAM T. BRODHEAD, MD, Madison
FRANCES A. CLINE, MD, RHINELANDER

The Division on School Health has met five times during the past year and has worked on several subjects of interest to all members of the Society.

In cooperation with the State Department of Public Instruction, a survey on physical education injuries was conducted to determine if certain schools have a greater percentage of athletic injuries than others. The survey revealed that no definite trend or reason for a greater percentage of injuries could be established. However, it was established that a publication on safety procedures to be used in connection with physical education programs is needed. The Department of Public Instruction has expressed interest in working with the Society on the preparation of such a booklet, and with the approval of the Council and the House of Delegates, the Division will proceed with this project during the next year.

Also considered in regard to athletic injuries was the "Guide for Interscholastic Athletic Disqualification—Junior and Senior High School Level." This guide has been reviewed. (The original guide appeared in the January 1967 issue of the *Wisconsin Medical Journal* at page 46.) The Division recommends that the Society officially adopt the revised guide (submitted with this report) and distribute it to all interested parties.

The role of the school nurse in school health programs also has been discussed at length and the Division recommends that the House support the "Statement on School Health Service Aids" (see Exhibit A at end of this report) that was prepared with the Division's consultation and advice. This statement should be considered for implementation throughout the state.

The Guide "School Health Examinations" which was previously distributed by the State Medical Society is being completely revised. The total project is not as yet completed, but when final recommendations are available they will be forwarded to all physicians and schools in the state. The proposed revision will be submitted for Council action and it is hoped that the Guide will be published with the

endorsement of the Division of Health of the Department of Health and Social Services and the State Department of Public Instruction. The area covered by the Guide includes the legal basis for school health examinations, the purposes of health examinations and the organization of such programs. Screening tests, procedures, suggestions for follow-up, conduct and preparation for examinations are all covered in the Guide. In addition, suggested forms and procedures for use by physicians and school administrators will be included.

The Division has also revised the "Report to Schools on Significant Findings of Health Examinations." This form, which was previously approved by the House will be circulated to all schools, and is included with this report (Exhibit B) for the information of the House.

Having completed a successful year on basic guides and programs, the Division expects to further consider necessary revisions of other specialized forms and publications used in connection with school health.

The necessity for more school health examinations, both for students and teachers, the need for adaptive physical education programs and consultation with the Wisconsin Athletic Association on Sports Competition for Students will be the primary work of the Division in the months ahead.

EXHIBIT A—Statement on School Health Service Aids

One of the continuing problems in schools is the maintenance of a health service which is adequate for the needs of all boys and girls and which provides special help to those with emotional or physical health problems. In the majority of Wisconsin schools this service is provided in large part by the public health nurses from city or county public health agencies. In addition, about 90 of the state's 510 districts either have employed a full or part time nurse or are considering employing one. Such nurses, who must have certification in public health to be legally employed, are becoming more and more difficult to find. At the same time the public health agencies are re-examining their programs, adding new services such as home nursing care, and finding ways to use more and more lay workers in their general health programs. And they, too, are continually looking for additional qualified nurses.

The school administrator is caught in the middle. He sees the need for more direct health services in his schools, more parents assume that health services are being provided, and directions for federally funded projects make recommendations and provide money.

One way out of the dilemma of finding people to do the job is the use of lay workers as school health service aids. This is really not new since schools have used non-medical persons to supplement health services for years. School secretaries, or clerks, teachers and principals as well as community volunteers have performed many health-related activities. However, these have been on an emergency or a hit-and-miss basis, with no overall plan that balances the needs of pupils and school staff with the availability of professional public health, medical and dental personnel and with financial support. Therefore, the following recommendations are presented for consideration by appropriate organizations.

It is recommended that school administrators, working with local public health medical and dental personnel should:

1. Review the need for daily health services in their schools, the recurring special health services (screening for vision or hearing, for example) and the plans for meeting emergency health situations.
2. Check on the availability of funds to support adequate school health services and the facilities provided in the schools.
3. Review the availability of professional public health, medical and dental manpower which can reasonably be depended upon for service this year and in the future and outline responsibilities of each in the school's health service program.*
4. Give serious consideration to the use of lay workers, who have been trained, as school health service aids.**

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* The American Nurses Association, *Functions and Qualifications for School Nurses* (1966). The School Branch of the Wisconsin Nurses Association has additional information.

(References to role of physicians and dentists and other specialists might be added.)

** Department of Public Instruction, *Lay Workers in the School Health Service* (mimeographed outline, September 1967).

This outline suggests that lay workers employed as school health service aides could perform such functions as the following, under the supervision of a qualified public health nurse:

1. Maintain the health room—keep records of requests for service
2. Assist with screening programs
   —find volunteers and arrange for training them
   —work with administrator and teachers to set up schedule
   —work with volunteers as screening is done
   —keep and record information from screening
   —maintain records of follow-up
   —may phone parents on such things as permission slips, etc.
3. Give first aid but not replace responsibility of the teachers or administrators
4. Check supplies for health room, notify appropriate person for replacements
5. Maintain emergency card file for each child
   —notify parent or guardian about sick or injured child
   —work with administrator in arranging to get such child home
6. Maintain health records, especially at junior and senior high level. (Does not replace responsibility of teachers for keeping, or using records)
7. Keep records of accidents, make summaries as directed
8. Refer health problems to public health nurse or administrator
9. Assist with resource material, ordering, filing, displaying, etc.
10. Do limited health counseling

VISIT

MUSEUM OF MEDICAL PROGRESS AND STOVALL HALL OF HEALTH

Prairie du Chien, Wis.

Open until November 1

See details on page 507

EXHIBIT B—Report to School on Significant Findings of Health Examinations

Date _____

School _____

Name of Student _____ Date of Birth ____ Grade ___

Name of Parents _____ Address _____

Medical conditions of significance to school authorities: _____

Please indicate, for purposes of follow-up, need for any specific medical, dental, psychiatric or surgical care including immunization: _____

Is student capable of carrying a full program of school work? No ___ Yes ___

Should there be restrictions on up and down stairs travel? Yes ___ No ___

Is special seating recommended? Yes ___ No ___

Does the student have irremediable defects? Yes ___ No ___

Is there evidence of emotional or behavior problems? Yes ___ No ___

Is there a need to restrict physical education activity? Yes ___ No ___

Should physical activity outside of school be limited? Yes ___ No ___

Please indicate any recommended restrictions from normal school activity including nature and duration:

Unrestricted Activity (full participation in physical education and athletic activities) _____

Moderate Restriction (participation in designated physical education and athletic activities) _____

Severe Restriction (participation in only a limited number of low level activities) _____

Reconstructive or Rehabilitative Activity (participation in a prescribed program of corrective exercises and adaptive sports with appropriate periods of rest) ___

Should student be seen again prior to next school health examination?

Yes ___ No ___ If yes, how soon? _____

Signature of Physician _____

Address _____

To Be Filled Out By School Personnel

Action taken on above recommendations: Date

(Prepared by: Division on School Health, State Medical Society of Wisconsin)

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended referral of the revised "Guide for Interscholastic Athletic Disqualification—Junior and Senior High School Level" back to the Division for clarification of physician responsibility, with authority in the Commission on State Departments to approve the Guide when that point has been satisfied. Recommended acceptance of the "Statement on School Health Service Aids" and the "Report to School on Significant Findings of Health Examinations."

HOUSE OF DELEGATES ACTION—Accepted the report of the Division on School Health as recommended by the Reference Committee.

Report No. 11

■ REPORT OF DIVISION ON ALCOHOLISM AND ADDICTION—May 1968

DAROLD A. TREFFERT, MD, Fond du Lac, Chairman
SEYMOUR L. HALLECK, MD, Madison
O. H. HANSON, MD, Fort Atkinson
JOSEPH P. LOOZE, MD, Milwaukee
FORDYCE A. ROSS, MD, Milwaukee
ROBERT G. ZACH, MD, Monroe
EDWARD C. SCHMIDT, MD, Milwaukee

The Division on Alcoholism and Addiction was formed by the Council, at the request of the House of Delegates, during the past year. The organizational meeting of the Division was held on November 9 and at that time, the scope of anticipated activities was considered.

First on the agenda was the review of the several definitions of alcoholism presently available, and the problem of terminology is still being considered in view of the proposed revision of the state's mental health laws. The work of the Legislative Council Committee in redrafting the mental health code, Chapter 51, Wisconsin Statutes, is being closely followed because it will provide for changes in the commitment procedures for alcoholics and drug addicts. As recommendations become more specific, the Division will review and make suggestions for Society policy to the Commission on State Departments and to the Council.

The need for a treatment center and rehabilitation program for physicians has been discussed, and the Division plans to meet with representatives of the State Board of Medical Examiners during the coming months in order to define the problem as it actually exists. Where financial assistance is needed, it is recommended that such assistance be channeled through the Charitable, Educational and Scientific Foundation of the Society. Rehabilitation programs designed specifically for physicians are non-existent and the development of recommendations for such a program will be made.

Health insurance for alcoholics has been discussed and it has been pointed out that while some carriers make coverage available to alcoholics and addicts, some Blue Plans and some commercial companies do not. Accordingly, the Division has recommended that the Commission on Medical Care Plans review the area of health insurance coverage for alcoholics with a view to broadening benefits.

Alcoholism seminars and postgraduate study plans have been reviewed and it is felt that the Division should jointly sponsor with other organizations, such as the Wisconsin Hospital Association and the Division on Alcoholism Services of the State Department of Health and Social Services, a program designed to cover the problems of treatment of alcoholism in general hospitals. In addition, the Division hopes to cooperate in the planning of the Wisconsin Work Week of Health in developing programs on alcoholism and drug addiction.

After reviewing present information sources, the Division has also decided to recommend to the University of Wisconsin Medical School that it make more recordings on the treatment of alcoholism available to physicians.

The Division has worked with the Advisory Committee to State Alcoholism Services and at its last meeting appointed a member to meet with this group. In addition, all physicians have been asked to cooperate with the Advisory Committee in program planning for alcoholism.

The Division has also considered the necessity of disseminating information regarding prescribing within the framework of the Harrison Narcotic Act,

and recommends that the January 1969 Blue Book issue of the *Wisconsin Medical Journal* review both federal and state requirements dealing with narcotics and dangerous drugs.

For the information of the House, a pamphlet on "Where To Get Help For An Alcoholic In Wisconsin" is included with this report. (The pamphlet is available upon request to the State Department of Health and Social Services.)

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Noted that the Division's report dealt primarily with its organizational development and some of the early considerations since its creation by the House last year. It further noted the suggestion that the 1969 Blue Book issue of the *Wisconsin Medical Journal* review both federal and state requirements dealing with narcotics and dangerous drugs.

HOUSE OF DELEGATES ACTION—Accepted the report of the Division on Alcoholism and Addiction as recommended by the Reference Committee.

Report No. 12

REPORT OF THE COMMISSION ON SAFE TRANSPORTATION—May 1968

JAMES L. WEYGANDT, MD, Sheboygan Falls, Chairman
E. E. ECKSTAM, MD, Monroe
RALPH F. HUDSON, MD, Eau Claire
FREDERICK BUNKFELDT, JR., MD, Milwaukee
WALTER F. SMEJKAL, MD, Manitowoc
RICHARD C. WIXSON, MD, Madison
ALLEN W. WITTCHOW, MD, Wisconsin Rapids
FRANK L. RUNDLE, MD, Madison
GLENN C. HILLERY, MD, Lancaster

The House of Delegates in May 1967 recommended to the Council that the Society's Division on Safe Transportation be elevated to commission status because of the increased importance of the medical aspects of safe transportation.

The Council granted commission status and at the first meeting of the newly formed group the scope of activities and the organizational plans for action were determined.

The main area of concentration for the Commission during the past year has been the development of guidelines for emergency medical services as required by the National Highway Safety Act. The House of Delegates previously requested that such guidelines be reported for its information, but as yet they have not been determined. The Governor's Office and other agencies of state government have set up several committees to develop standards and the Commission is working closely with these committees. Members of the Commission have been appointed to the various committees of the State Task Force on Highway Safety and they will be reporting to the Commission so that final Society policy on proposed guidelines can be adopted.

Basic guidelines must be developed to train nonmedical personnel in emergency care concepts, to develop communications media for emergencies and to develop standards for training personnel involved in transporting the ill and the injured. Finally, standards for emergency room care must be developed. This particular subject has been assigned to the Commission on Hospital Relations and Medical Education. The overall planning and development will include many of the recommendations made at the American Medical Association's 1967 Conference on Emergency Medical Services. These standards are set forth for the Delegates information. They, of course, are not finalized and must be studied in detail and amended to fit situations peculiar to the Wisconsin situation.

The general guidelines on three phases of the emergency system with which the Commission is working are:

First Aid

1. All segments of the public should be trained in Red Cross standard first aid, or equivalent.
   (a) Training should be part of the curriculum of elementary and secondary schools.
   (b) First aid training should be encouraged for adult programs.
   (c) Management and labor should include Red Cross standards as part of its industrial safety training program.
2. Review of first aid, the fundamentals of emergency medical treatment and the appropriate role of allied health professionals should be an early part of medical, dental and nursing school curricula.
3. Advance first aid training should be required for all police and fire personnel.
4. All ambulance attendants should be given a minimum of advance first aid training and additional training in specific emergency medical care. Annual refresher courses should be given ambulance attendants.
5. Local medical societies should offer assistance and advice to local Red Cross chapters, police and fire academies and any other parties involved in teaching first aid.

Communications

1. A study should be made of available information on existing emergency communication systems relating to urban and rural areas. Information should include:
   (a) Data on cost
   (b) Distance
   (c) Installation
   (d) Controls
   (e) Equipment
   (f) Periodic investigation
2. Emergency communications should include but not be limited to the following 24-hour capability:
   (a) To provide central dispatching
   (b) To direct 2-way communications between emergency vehicles and emergency facilities
   (c) To have flexibility to handle emergencies of any magnitude
   (d) To provide 2-way communication between physicians and emergency facilities
   (e) To provide 2-way communications with law enforcement agencies and other agencies charged with emergency services.

Transportation

1. The minimum equipment for ambulances as specified by the American College of Surgeons should be accepted with certain additions including antidotes for poison control.
2. Every ambulance should have at least two attendants available for on-the-scene care and care enroute to the hospital.
3. Specific courses in defensive driving should be required for all personnel driving emergency vehicles.
4. A model ambulance ordinance should be endorsed and promoted.
5. Occupations of ambulance driver and attendant should be developed to a "career status" to enhance recruitment and stability.
6. Study should be made of the feasibility of helicopter use in transporting the ill and injured both in urban and rural areas.

The Commission also concurs with the position of the AMA which urges medical involvement in community action committees formed to deal with the establishment of emergency services. It should

be emphasized that emergency service systems are of basic importance and like fire and police protection, are a community responsibility.

In the area of transportation, the Commission reminds the Delegates that the House has already adopted a statement on the Transportation of the Ill and Injured prepared by the Society's Division on Safe Transportation. (Printed in August 1964 issue of *Wisconsin Medical Journal* at page 360.)

In addition to working on standards for emergency medical services, the Commission has considered the area of guidelines for physicians requested by police officers to perform tests for intoxication. The Society attorneys have recommended that such tests be done only upon the written order of a police officer and that the physician should attempt to obtain the consent of the patient in writing as an additional protection. Forms and general guidelines will be reported to the Council and it is recommended that these be forwarded to the membership once they have been adopted.

The Commission during the past months also developed a program on the medical aspects of traffic safety and rescue. This program, which was well received, was presented during the 1967 Wisconsin Work Week of Health and included speakers on the following subjects:

. . . "The Role of Medical Conditions in Accident Causation"
. . . "Detection of the Medically Impaired Driver"
. . . "Drugs and Driving"
. . . "Problems of the Motorcycle Boom"
. . . "Rescue of Accident Victims in Rural Areas"
. . . "Rescue of Accident Victims in Metropolitan Areas"
. . . "Communications in Traffic Rescue Efforts"

The Commission has recommended to the Editorial Board of the *Wisconsin Medical Journal* that it consider publishing certain of the papers delivered during this meeting because of the great number of requests for reprints that have been received from both state and national sources.

Standards for school bus operators have been discussed and the Commission on Public Policy, upon

Photography Exhibit Winners

BEST IN SHOW

Joseph L. Teresi, MD, Brookfield, *The Portico.*

MEDICINE—Color

(1) James R. Hoon, MD, Sheboygan, *The Seven Hands of Nakayama.*
(2) J. Martin Johnson, MD, Ripon, *Urticaria—Food Allergy.*
(3) John B. Baker, MD, Milwaukee, *Calvarial Metastases.*

TRAVEL—Color

(1) Jack L. Teasley, MD, Milwaukee, *Boat Landing, Interlachen.*
(2) Jack L. Teasley, MD, Milwaukee, *Sunset, West Indies.*
(3) Jack L. Teasley, MD, Milwaukee, *Woman and Statues.*

Honorable Mention: James R. Hoon, MD, Sheboygan, *The Dragon of Kannon Temple.*

TRAVEL—Black and White

(1) Paul J. Meis, MD, La Crosse, *Chateau.*
(2) Paul J. Meis, MD, La Crosse, *Hall of Mirrors.*
(3) Donald S. Schuster, MD, Madison, *I.F.R.*

PEOPLE—Color

(1) Jack L. Teasley, MD, Milwaukee, *Who's Down the Well.*
(2) David W. Kersting, MD, Milwaukee, *Little Boys at Sunset.*
(3) Robert G. Wochos, MD, Green Bay, *Fisherman of Martinique.*

Honorable Mention: Marvin G. Peterson, MD, Lake Mills, *Hong Kong Madonna.*

PEOPLE—Black and White

Paul J. Meis, MD, La Crosse, *Jazzmen.*

ANIMALS—Color

(1) Robert G. Wochos, MD, Green Bay, *Friend of the Family.*
(2) N. A. Eidsmoe, MD, Rice Lake, *Ghost of the Old West.*
(3) John Erbes, MD, Milwaukee, *Summer Haircut.*

PICTORIAL—Color

(1) Joseph L. Teresi, MD, Brookfield, *The Portico.*
(2) Marvin G. Peterson, MD, Lake Mills, *Japanese Garden.*
(3) William G. Kendell, MD, Fond du Lac, *Lakeside Park.*

Honorable Mention: Joseph L. Teresi, MD, Milwaukee, *Moon Huts;* and Harold J. Conlon, MD, Milwaukee, *Lake Superior, South Shore.*

PICTORIAL—Black and White

(1) Frank C. Stiles, MD, Monroe, *Old Stagecoach Road.*
(2) Paul J. Meis, MD, La Crosse, *Winter Patterns.*
(3) Joseph L. Teresi, MD, Brookfield, *Crisses and Crosses.*

BEST IN PHOTOGRAPHY EXHIBIT—"The Portico" won the Best in Show honor as well as first place in the pictorial-color division. Drs. William D. James, of Oconomowoc, new president of the State Medical Society, and an unidentified alternate delegate view Dr. Joseph L. Teresi's winning picture.

recommendation of the Commission on Safe Transportation, supported Assembly Bill 890. This legislation attempted to upgrade existing standards and the Commission recommended that the standards provide for physical examination on an annual basis. In addition, it is felt that physical standards must be established. The Commission has also recommended that the legislation should eliminate any grandfather provision and any reference to an upper age limit.

In response to the increase in the toll of injury and death from automobile accidents in the past few years, more and more legislation is being proposed which would require physicians to report to state officials those impairments in patients which might interfere with safe driving. The medical profession has always had serious objection to legislation which interferes with confidentiality of medical records and with the traditional physician-patient relationship. For this reason, the Commission concurs with the recent position adopted by the American Medical Association on this subject. That position as presented by the AMA Committee on Medical Aspects of Automotive Safety is as follows:

> "The Committee believes that the solution of the problem of reporting medically unfit drivers could better be achieved through the adoption of the principles expounded in its statement 'Determination of Need for Medical Evaluation in Driver Licensing.' This statement advises that local licensing authorities be trained to screen license applicants, that standardized criteria be developed and that medical examination be given only to those applicants who may present an unwarranted risk. Under such a plan physicians would not be put in the position of having to report medical conditions, but instead would determine only whether the examinee met prescribed standards.
>
> "In addition, medical advisory boards to state licensing departments are proposed for all states. . . ."

The Commission recommends to the House of Delegates that it encourage the development of medical advisory boards on a local or regional basis for the State of Wisconsin. One such board has already been considered by Milwaukee County and it is the opinion of the Commission that such a plan should be encouraged throughout the state.

The Commission has been represented at several national meetings including the annual meeting of the American Association for Automotive Medicine and the AMA Conference on Emergency Medical Care. Reports on these meetings have been made to the Council and information is available to all interested physicians.

In closing, the Commission would like to report that upon its recommendation, the Council of the State Medical Society has commended Herman Heise, M.D., formerly of Milwaukee, for the outstanding leadership and contributions in the field of medical aspects of safe transportation. Such leadership, as demonstrated by Doctor Heise, will prove greatly beneficial to the public health and safety of all Wisconsin citizens.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Concurred with the position of the Commission in its recommendation on the creation of medical advisory boards to state motor vehicle operators' licensing departments on a local or regional basis. It urged the House to adopt the recommendation of the Commission and the American Medical Association that the medical profession become involved in community action committees formed to establish emergency services in Wisconsin. Commended the Commission for its work in the area of setting standards for school bus operators, and recommended that legislation on this subject be once again introduced in the 1969 session.

HOUSE OF DELEGATES ACTION—Accepted the report of the Commission on Safe Transportation as recommended by the Reference Committee.

Report No. 13

REPORT OF DIVISION ON VISION—May 1968

JAMES V. BOLGER, JR., MD, Waukesha, Chairman
GLEN E. McCORMICK, MD, Milwaukee
RALPH T. SPROULE, MD, Milwaukee
ALLEN W. WITTCHOW, MD, Wisconsin Rapids
C. G. KIRCHGEORG, MD, Neenah
GEORGE NADEAU, MD, Green Bay
DONALD A. PETERSON, MD, Madison
JOHN B. HITZ, MD, Milwaukee
JOHN A. OTTUM, MD, Green Bay
C. G. REZNICHEK, MD, Madison

The Division has devoted the majority of its time during the past year to a revision of the guide for setting up visual screening programs for school children. The revision is intended for teachers, school and public health nurses, health educators and school health officials, as well as anyone else interested in the detection of eye and vision problems in our Wisconsin youth.

The guide provides a brief and understandable explanation of the workings of the eye, how we see, some of the common defects, and what can be done to treat, correct and prevent visual disorders. Emphasis is logically placed on the vision of the preschool and school child.

The guide will cover such areas as:

(a) Elementary function of the eye
(b) Causes of decreased visual acuity
(c) Binocular vision
(d) Treatment of amblyopia and strabismus
(e) First aid for eye emergencies and eye safety
(f) Preschool vision screening
(g) Vision reading and learning
(h) School vision testing procedures

An additional purpose of the guide will be to act as an organizational format for screening programs. Final drafts will be submitted to the Commission on State Departments and the Council of the Society. It is expected that this material will be available for distribution during the 1968–69 academic year. Publication costs have not as yet been determined, but it is anticipated that a request for partial assistance and approval of the publication will be made to the State Department of Public Instruction and the Division of Health of the Department of Health and Social Services. The Commission on State Departments will correlate the revision of the School Health Examination Guide being done by the Division on School Health with the new Guide for Visual Screening.

In addition to working on the screening guide, the Division is working with the Wisconsin Industrial Commission on standards for determining visual impairment. A study is being conducted on the standards presently being used by the Industrial Commission, and the results which would be obtained if the American Medical Association's suggested guide was adopted as the Wisconsin standard. Results of this study will probably not be available for at least another year, but the Division feels that the members of the House should be aware of the fact that this previously approved activity is well underway.

Revision of the report forms used by the Bureau for Handicapped Children of the Department of Public Instruction is also a current project of the Division. After the new form has been finalized and Division recommendations incorporated, it will be made available to all members of the Society.

Not only has the Division worked with the various agencies of state government during the past year in giving advice and consultation, it has also worked with other Society commissions and committees. Dr. Ralph T. Sproule of Milwaukee and Dr. C. G. Kirchgeorg of Neenah have been appointed to a Subcommittee on Visual Standards. This Committee meets with other Society committees to discuss problems of medical eye care and to give advice on appropriate visual standards. For example, this Subcommittee has met with the Commission on Safe Transportation to discuss appropriate standards and requirements for visual acuity for motor vehicle operator's licenses.

In addition, the Division on Vision this year has coordinated its activities with the Section on Ophthalmology of the Society and has actively worked with the Education Committee of that Section in planning the eye program for the 1968 Annual Meeting.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Commended the Division for its accomplishments since it was separated from the Division on Ear, Nose and Throat. Noted that it is looking forward to the accomplishment of final drafts on a new guide for setting up visual screening programs for school children.

HOUSE OF DELEGATES ACTION—Accepted the report of the Division on Vision as recommended by the Reference Committee.

Report No. 14

■ REPORT OF THE COMMISSION ON PUBLIC POLICY—May 1968

W. T. RUSSELL, MD, Sun Prairie, Chairman
C. F. BRODERICK, MD, Wisconsin Dells, Vice-chairman
J. M. LUBITZ, MD, Brookfield
L. J. KURTEN, MD, Racine
E. C. QUACKENBUSH, MD, Hartford
L. W. SCHRANK, MD, Waupun
T. E. HENNEY, MD, Portage
R. L. GILBERT, MD, La Crosse
J. B. DURST, MD, La Crosse
P. K. ODLAND, MD, Janesville
S. A. FREITAG, MD, Janesville
A. D. ANDERSON, MD, Madison
J. L. TERESI, MD, Brookfield
D. S. SCHUSTER, MD, Madison
N. G. BAUCH, MD, Milwaukee
J. A. VanSUSTEREN, MD, La Crosse
LYLE EDELBLUTE, MD, Green Bay
K. L. SIEBECKER, JR., MD, Madison
H. A. PETERS, MD, Madison
EDWARD J. ZEISS, MD, Appleton
P. A. SCIARRA, MD, Sheboygan
J. F. MORRISSEY, MD, Madison
J. R. SCHRODER, MD, Janesville
H. J. KIEF, MD, Fond du Lac
W. D. JAMES, MD, Oconomowoc

Long range planning and recommendations of the Commission for the 1967 session of the Wisconsin Legislature were presented and approved by the House of Delegates in May 1967. However, since its last meeting the Legislature has met several times and this report is intended to give the current status of some of the bills considered by the Society. It must be noted that it is expected that the Wisconsin Legislature will not be in session again until January of 1969 and this report then, for practical purposes, represents a final analysis of the action for the 1967 session.

A total of 1,976 bills was submitted to our State Legislature during the past year and of these approximately 200 were of concern to physicians and their patients.

Legislation which affects hospital privileges for osteopaths was passed in the form previously recommended by the House of Delegates. The bill provides that a hospital cannot deny staff privileges to an individual solely because he is an osteopath but that privileges may be denied if the applicant fails to show that he has the necessary training, experience and competence.

In the area of medical licensure, a bill was passed which increases the number of temporary educational certificates that may be outstanding at any one time. This legislation had the support of the Society.

Chiropractic attempts to obtain licenses by reciprocity and to have their services paid for under Workmen's Compensation and under Title 19 (Medicaid) have had no final action. The Society continues to oppose unwarranted attempts such as these. A Joint Resolution calling for a study of chiropractic is still pending consideration by the Assembly Public Welfare Committee.

The Commission, with the advice of the Division on Ear, Nose and Throat, supported a bill which would license hearing aid dealers provided that amendments were introduced by the Hearing Aid Dealers Association to assure medical examinations before fitting such devices. No amendments were introduced and hence the Society has not supported this legislation. However, it is expected that a similar proposal may be introduced in the 1969 session and at this time the Commission will also insist on amendments which will protect the hearing aid buying public.

Other legislation in which the Divisions on Ear, Nose and Throat and Public Policy collaborated was Assembly Bill 972. This proposal would have set unrealistic limits for the driving qualifications for the hard of hearing and Society representatives pointed out scientific reasons why corrective amendments were needed.

Assembly Bill 873 would limit sterilization to hereditary mentally defective patients and the Commission, like other committees of the Society, is waiting for the Attorney General to rule on elective sterilization as requested by the State Board of Medical Examiners.

The Society has supported Assembly Bill 916 which provides for the licensing of radioactive material and also reviewed Senate Bill 491 which would repeal the present prohibition against the shipment in interstate commerce of live dogs and cats for research purposes. Both bills are being followed to insure that no amendments are introduced which would make enactment detrimental.

The Society was among those groups supporting the classification of LSD as a dangerous drug. It also took the lead in supporting proposals which would provide civil immunity as well as the criminal immunity to those required to report suspected cases of child abuse.

Senate Joint Resolution 76 was introduced at the request of the State Medical Society and if enacted will permit a county or group of counties to establish a medical examiner system in lieu of the office of coroner.

The Commission during the past year has worked closely with the Commission on Safe Transportation in support of highway safety legislation. In addition to supporting the Governor's traffic safety program, the Society also supported the enactment of legislation which would set up standards for obtaining school bus operator's licenses. Safety on the highway was not the limit of safety considered by the Commission. In cooperation with the Section on Ophthalmology and the Division on Vision, legislation was introduced which would have required students in certain academic classes to wear safety glasses.

Continued support of this legislation is proposed for the next legislative session.

Legislation which was opposed was that which would have changed the statute of limitations on malpractice to that of three years from the time that a person receiving treatment should have reasonably been aware of the injury. The present statutes place the limit at three years after date of last treatment.

One of the most important bills enacted into law thus far in the 1967 session is the bill reorganizing the state government (Chapter 75, Laws of 1967). The Society took a very active position on this legislation from its inception and helped draft various provisions for the protection of the health of the people of the state. In its final form, this bill assures the continuing autonomy of the State Board of Medical Examiners by recognizing the special needs of the professional licensing board. Also, the role of the State Board of Pharmacy in the control of drugs is maintained. The State Board of Health, although merged as an administrative unit with the Department of Public Welfare, was given a transfer maintaining it most nearly as a recognized and separate unit. Several functions originally recommended for removal from the Board were maintained in it, and the current policy board is retained as the Council on Health.

The Society has supported in principle, the proposed creation of a legislative agency known as the Council on Sciences. This Council would review all legislation pertaining to health matters. In addition, a bill which would create a joint survey committee on compulsory medical reports and tests has been supported by the Society but has had no final action.

In considering family planning legislation, the Commission on Public Policy reaffirmed its position which was previously approved by the House in May of 1967. The Commission feels that that position should be once again reaffirmed. Action taken by the House last year is as follows:

> ". . . legislation which would remove birth control information and devices from the present statutory definition which defines them as indecent articles has received the general support of the Executive Committee of Public Policy. The Executive Committee has concurred with the position of the American Medical Association in its statement that physicians must assume the role of leadership in the area of family planning in our society."

At the request of the Division on Nervous and Mental Diseases, the Commission on Public Policy opposed Assembly Bill 324 which would have created a state coordinating council on mental health and retardation and actively supported Assembly Bill 664 which would have established community mental health, alcoholism and mental retardation services. It was recommended that psychiatric hospitals as well as general hospitals be eligible to participate in the program being established and that the wording under 51.41 (9) be revised to make it clear that county boards contract with hospitals for hospital costs only and not for the cost of medical services.

The Society opposed Assembly Bill 728 which would have permitted cooperative associations to establish facilities to provide sickness, hospital and dental care. In addition, the Society also opposed the expansion of optometric services under Medicaid and went on record stating that these types of services should not be reimbursable whether performed by physicians or optometrists.

The Conference on Health Fads and Fallacies was held in Milwaukee on November 13 and 14 and it is the recommendation of the Commission that a statewide conference such as this not be planned for 1968. However, the Society will continue its efforts to combat quackery and the Commission plans to step up its investigative program in this area. It is recommended that in lieu of a statewide conference for 1968 assistance be given to county societies in establishing seminar type programs.

In summary, this report is intended to highlight some of the legislation considered by the Commission on Public Policy. It is not intended to be a comprehensive listing, but information and a status report on all bills and joint resolutions reviewed is available upon request to any member of the State Medical Society.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended that the House again go on record in support of legislation which will permit a county or group of counties to establish a medical examiner system in lieu of the office of coroner. Recommended that the House reaffirm its position taken last year, which supported in principle legislation which would remove birth control information and devices from the present statutory definition which defines them as indecent articles. Pointed out to members of the House that legislation was passed which provides civil as well as criminal immunity to those required to report suspected cases of child abuse. Noted that support of this legislation was previously recommended by the House, and that its implementation should be made known to all Wisconsin physicians. Concurred with the recommendation of the Commission that, in lieu of a statewide conference on Health Fads and Fallacies for 1968, it provides assistance in programming to county societies so that they can establish seminar-type programs.

HOUSE OF DELEGATES ACTION—Accepted the report of the Commission on Public Policy as recommended by the Reference Committee, with one dissenting vote.

Report No. 15

REPORT OF COUNCIL

JAMES C. FOX, MD, La Crosse, Chairman

Minutes of Council meetings held since the last session of the House of Delegates have been published in the *Wisconsin Medical Journal* (July 30, 1967 minutes appeared in the October 1967 issue at page 528; Nov. 4, 1967, January 1968 issue, page 110), except those of its March 1968 meeting. (Subsequently printeed in the May 1968 issue at page 281.)

Two items referred to in the minutes are separately included in this report for ease of reference:

1. Proposed amendment of Chapter XI, Sec. 3, of the Bylaws
2. 1968 Operating Budget—SMS General Fund

Also included is the annual necrology report.

The Council will meet again before the first session of the House in May and will have a further report at that time.

Proposed Bylaw Amendment—Chapter XI, Sec. 3

In recognition that it is now more common for a physician to maintain his residence in a county other than that in which his principal place of practice is located, the Council proposes the following amendments to Chapter XI, Sec. 3, of the Bylaws:

NOTE: Words in parentheses denote deletion and words in italics denote changes of present bylaw:

> Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician (who is a bona fide resident of) *whose principal practice is within* the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the

PAST PRESIDENTS of the State Medical Society gathered at a dinner given in their honor by the Councilors and Officers. Left to right, standing: Drs. Joseph C. Griffith, Milwaukee; Gunnar Gundersen, La Crosse; L. O. Simenstad, Osceola; William P. Curran, Antigo; Edmund D. Sorenson, Elkhorn; Ervin L. Bernhart, Milwaukee; M. A. McGarty, La Crosse. R. P. Sproule, Milwaukee; A. J. McCarey, Green Bay; H. Kent Tenney, Madison; seated: Karl H. Doege, Marshfield; Nels A. Hill, Madison; William D. James, Oconomowoc (president); Frank E. Drew, Milwaukee; Harold J. Kief, Fond du Lac; William J. Egan, Milwaukee; William D. Stovall, Madison; and H. E. Kasten, Beloit. Only two were missing: Drs. L. H. Lokvam of Kenosha and W. B. Hildebrand of Menasha.

Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have (resided) *practiced* within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked, suspended, or voluntarily surrendered, shall be dropped from membership automatically as of the date of revocation, suspension, or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician's county society membership must be held in that county in which his principal practice is located. However, a physician living near a county line may hold his membership in that county most convenient for him to attend *meetings,* on permission of the component society in (whose jurisdiction he resides) *which county he maintains his principal place of practice.*

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

Necrology Report

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are printed in italic.

A. H. Knudson, Milwaukee
J. A. Litzow, Stevens Point
I. E. Schiek, Rhinelander
I. T. Stemper, Oconomowoc
M. S. LeTellier, Green Bay
E. B. Elvis, Madison
S. D. Beebe, Sparta
G. S. Kilkenny, Milwaukee
E. A. Loomis, Janesville
M. M. Scheid, Rosendale
J. W. Connell, Sheboygan
Harold Guzzo, Washburn
M. D. Davis, Milton
T. W. Dasler, Marshfield
R. S. Baldwin, Port Charlotte, Fla.
Louis Schmit, Milwaukee
H. J. Belson, Manitowoc
W. M. Kearns, Milwaukee
N. C. Erdmann, Manitowoc
H. P. Conway, Spring Valley
H. C. Johnson, Eugene, Oregon
F. W. Seegers, Milwaukee
J. C. Wilets, Milwaukee
G. R. Sandgren, Suring
R. C. Thackeray, Wausau

R. S. Wright, Racine
P. C. Wagner, Milwaukee
W. C. Felton, Milwaukee
L. H. Nowack, Watertown
D. W. Bailey, Milwaukee
F. K. Kolb, Sheboygan
G. J. Schweitzer, Milwaukee
C. J. Corcoran, Milwaukee
R. M. Moore, Frederic
J. J. Kronzer, Oshkosh
J. L. Kruszewski, Milwaukee
R. O. Grigsby, Ashland
R. C. Faulds, Abrams
J. E. Haberland, Milwaukee
J. D. Walsh, Oak Park, Illinois
W. W. Bauer, Chicago, Illinois
A. H. Lahmann, Mequon
E. A. Miller, Clintonville
F. J. Schubert, Ft. Lauderdale, Fla.
D. F. Hudek, Bloomer
N. M. Mauel, Cashton
F. J. Pfeifer, New London
L. W. Gregory, Oakland, California
A. W. Kozelka, Two Rivers
A. J. Kampmeier, Milwaukee
C. T. Dunham, St. Petersburg Beach, Florida
H. A. Bolstad, De Soto
E. C. Van Valin, Sussex
Henry Blank, Milwaukee
B. J. Malnekoff, Milwaukee
Michael Kasak, Milwaukee
F. S. Rybak, Madison
L. O. Mastalir, Milwaukee
H. C. Miller, Whitewater
M. K. Dubinski, Angola, Indiana
L. M. Gorenstein, Fort Myers, Fla.
W. W. Stebbins, St. Petersburg, Fla.
Oscar Knutson, Osseo
K. C. Kehl, Racine
J. H. Houghton, Wisconsin Dells
C. F. Neacy, Palas Verdes Estates, California
C. C. Reinke, Milwaukee
A. W. Peelen, Milwaukee
C. F. McDonald, Milwaukee

Supplementary Necrology Report

Council added to the report the death of the following physicians since the original report was written:

Dr. Earl W. Martens, Wauwatosa
Dr. Frank C. Kinsman, Eau Claire
Dr. Charles N. Lewis, Madison
Dr. George F. Malin, La Crosse
Dr. G. M. Shewalter, Clearwater, Florida

State Medical Society of Wisconsin
General Fund

PROPOSED OPERATING BUDGET—1968

Comments

GENERAL. As requested at the October, 1966 interim session of the House of Delegates, the proposed budget is being presented with corresponding 1967 experience.

Any budget is an estimate of the anticipated experience. A combination of past experience and future planning was used to determine the 1968 Proposed Operating Budget.

Following are some comments on a few of the budget items.

INCOME. *Dues* income will increase only slightly over 1967, unless there is more than the normal increase in membership. Total membership (all classifications) at 12/31/67 was 4,045.

Reimbursement for Work Performed—Wherever possible, these costs are offset directly against the appropriate expense account; but whenever they cannot be identified as such, they are recorded as income.

The Wisconsin Medical Journal income for 1968 is down slightly from 1967 primarily because of an anticipated decrease in advertising revenue brought on by uncertainties in the drug industry.

EXPENSES. *General*—Added activities have affected nearly every expense category. A few of these are:

Wisconsin Association of Professions was assigned as an SMS project. There are now over 400 members. Staff time and expenses increase with the larger membership and increased activities.

Medical education—The medical schools' activities have increased.

Some scientific sections are becoming very active. Additional staff time and expense is also required in these activities.

Equal Employment Opportunity (EEO) regulations have made additional demands on staff, such as lengthy conferences and detailed reports.

Some projects have been carried for several years. Most of these are good for medicine and should be continued as is or expanded, which may take additional funds.

Payroll (excluding Field Service) represents 34.8% of the total proposed budget. It is based on salaries at 1/1/68 and includes a reasonable factor for increases.

Payroll Related Expenses—Social Security Tax rate remains at 4.4% in 1968; however, the base increases from $6,600 to $7,800.

Group insurance premiums will increase.

State Unemployment Compensation rates will increase from .8% to 1.8%.

Conference Expense—Although this account was over-expended by $5,543 in 1967, it is felt with some changes at the AMA and other meetings, this expense item may be less than 1967.

Staff Travel Expense—Additional activities and staff will result in increased travel.

Telephone and Telegraph charges for 1967 include SMS portion of a Wide Area Telephone Service (WATS) long distance line. In 1968, this will be paid by SMS Realty Corporation and charged to the tenants (SMS and WPS) as part of the basic office rental.

Printing and Forms—A major portion of this is for printing the *Wisconsin Medical Journal*. During the last half of 1967, costs of printing the WMJ increased 37%. Hopefully, these costs can be decreased by consolidation of certain items and possible elimination of others so as to reduce the number of pages. Printing, editorial, and distribution costs are approximately $75 per page.

Promotion—Medical Memos will be discontinued in 1968.

Outside Services—1967 expenditures due, in part, to Workmen's Compensation Open Panels, Conference on Health Fads and Fallacies, and the Annual Meeting. However, the major portion was due to services required by scientific sections, a portion of which may be recovered in 1968. It is anticipated these services will not be needed to such a great extent in 1968.

Rent (Central Office)—Additional activities create needs for more staff; more staff means more floor space occupied and additional services required of SMS Realty Corporation. These combined create the need for additional rental charges.

Special Budgetary Provisions—The 1967 Adjusted Budget includes carry-over items from prior years as follows:

Workmen's Compensation—Open Panels	$ 7,880
Health Fads and Fallacies	3,525
Presidents' Room Dedication	2,500
	$13,905

Expenditures in 1967 include $10,600 for Workmen's Compensation Panels, $2,500 for Presidents' Room dedication and $9,300 for Health Fads and Fallacies; among others. Of these three projects, only $4,000 for Workmen's Compensation Panels and $1,000 for Health Fads and Fallacies are included in the 1968 Proposed Budget.

Thus, the 1968 Budget is proposed as:

Town and Gown Symposium	$ 1,500
Work Week of Health	10,000
Industrial Health Clinic	500
Special Mailings—*Today's Health*, etc.	5,000
Memorials to CES Foundation	1,000
Workmen's Compensation Panels (Carry-over)	4,000
Contingency—includes $1,000 stand-by for Health Fads	3,000
	$25,000

Field Service—Increased activities and utilization of this function will necessitate additional staff in 1968, but expense will not be felt until later in the year.

State Medical Society of Wisconsin

INCOME

	1967 Actual	1968 Projected
Dues—State Medical Society Includes dues from all membership classifications.	$437,434	$441,000
Annual Meeting Exhibit booth rentals, round table luncheons and other	33,519	33,500
Reimbursement for Work Performed Office services for Dane County Medical Society AMA collection fees Costs incurred in performing certain functions for the Realty Corporation, WPS and other activities are recovered. When they cannot be offset against any particular expense accounts, they will be considered income.	19,638	20,000
Wisconsin Medical Journal Advertising, reprints and subscriptions	56,148	55,000
Investment Income Interest on short term U. S. Government securities	4,230	4,500
Dues—Section on Medical History These funds are not available for general Society purposes, but rather to implement activities of the Section on Medical History, aid in the acquisition of memorabilia and the development of exhibits.	1,315	1,350
Miscellaneous Occupational Health Guides, bound volumes of Workmen's Compensation Open Panels and other printed material	1,669	1,600
TOTALS	$553,953	$556,950

State Medical Society of Wisconsin

PROPOSED 1968 OPERATING BUDGET

Account and Description	Adjusted 1967 Budget*	1967 Expenses	Expenses (Over)–Under Budget	1968 Proposed Budget
Payroll (Excludes Field Service) Current annualized payroll plus adjustments during the year	$166,380	$169,995	($3,615)	$195,300
Payroll Related Expenses Pension plan contributions, Social Security Tax, employees group insurance and unemployment compensation—will be 14% of total payroll in 1968	24,465	20,203	4,262	31,900
Conference Expense Council and committee meetings, including expenses billed by physicians and consultants Expenses of attending national and regional conferences AMA delegates' and alternates' expenses for two meetings President and President-elect travel Annual Meeting expenses—partially recovered in income	28,870	34,413	(5,543)	29,500
Association Dues The Society holds membership in organizations such as the Student AMA, Wisconsin Association of Professions, Wisconsin Health Council, Better Business Bureau of Milwaukee, American Hospital Association and the U. S. Chamber of Commerce. It also supports and participates in the North Central Conference.	1,623	1,890	(267)	1,900
Staff Travel Expense Expenses relating to travel by staff members on Society business Does not include Field Service travel Partially recoverable in income	10,753	9,285	1,468	10,500
Telephone and Telegraph Normal toll charges 1967 expense includes part of WATS line, but in 1968 this will be included in office rental charges	3,764	4,002	(238)	2,600
Resource Material Legislative Service Normal Subscriptions and Publications	1,083	1,160	(77)	1,200
Printing and Forms Wisconsin Medical Journal printing costs increased 37% in 1967 Annual Meeting items such as delegates' band books Woman's Auxiliary printing such as letterhead, envelopes and Badger Doctors Wife Special legislative bulletins SMS letterhead, envelopes and other routine printing WMJ and Annual Meeting items are recoverable in income	50,057	52,825	(2,768)	50,000
Postage Routine requirements Early in 1968 most postage rates were increased 20%	12,478	11,669	809	14,100

(Continued on next page)

PROPOSED 1968 OPERATING BUDGET—Continued

Account and Description	Adjusted 1967 Budget*	1967 Expenses	Expenses (Over)-Under Budget	1968 Proposed Budget
Office Supplies and Expense Normal requirements for office use such as carbon paper, pencils, file folders and mimeograph supplies	3,121	1,310	1,811	1,500
Promotion Educational exhibits, special pamphlets for distribution, photographs and cuts for news releases, medical memo Annual Meeting promotion partially recovered in income	6,676	8,139	(1,163)	5,200
Insurance—General Basic insurance coverage for the Society as determined by staff and consultants	2,760	2,797	(37)	2,800
Grants and Appropriations Portion of dues applicable to PACE and Woman's Auxiliary Support of State 4-H and Student AMA activities CES Foundation to support teaching programs Aid to needy physicians	30,820	27,520	3,300	27,500
Cafeteria Expense SMS share of cafeteria loss	1,695	2,104	(409)	2,100
Speakers Expense Annual Meeting speakers' honoraria and related expenses—partially recovered in income	3,890	4,210	(320)	4,200
Outside Services Services of additional personnel for the Annual Meeting March of Medicine—recording and emcee, Doctor Tenney Clipping service	9,100	19,022	(9,922)	14,000
Miscellaneous Expenses Items too small in amount or not occurring frequently enough to be classified as separate accounts	3,377	4,597	(1,220)	4,600
Accounting—Audit Services Services of the independent CPA firm	6,467	5,071	1,396	5,500
Legal Services Legal services in areas of general administration, grievance investigations, membership problems and other areas	7,094	10,112	(3,018)	10,200
Special The above are routine services provided by legal counsel, but to an increasing degree special matters are presented during the course of the year which require action that cannot be anticipated at the time the budget is prepared. A contingency account of $5,000 is needed year in and year out.	5,000	5,000	—0—	5,000
Legislative Retainer With the ever increasing effect legislation is having on the medical profession, it has become necessary to retain the services of another individual in this area. Some of these expenses may be recovered from the Section on Ophthalmology.	10,138	13,400	(3,262)	9,300
Depreciation Computed at current rates on existing equipment and projected for 1968 equipment purchases	3,212	2,168	1,044	2,500
Rent—Central Office Rent on space occupied by personnel assigned to the SMS and WMJ	42,783	41,002	1,781	59,600
Rent—Other Auditorium rental for the Annual Meeting—partially recovered in income	7,058	6,065	993	6,100
Rent—Equipment Equipment rented for Annual Meeting partially recovered in income Bruning copy machine	1,600	1,175	425	1,200
Repairs and Maintenance—Equipment Service agreements and repairs on office equipment	1,091	985	106	1,000
Property Taxes—Personal Property Property tax on office equipment	406	631	(225)	800
Special Budgetary Provisions 1967 Budget $31,350 Prior year's budget carry-overs 13,905 Total $45,255 Town and Gown Symposiums Wisconsin Work Week of Health Industrial Health Clinics Special mailings of Today's Health, AMA News and other special material Memorials to CES Foundation for deceased members Workmen's Compensation Open Panels Contingency Fund—includes $1,000 stand-by fund for Health Fads and Fallacies	45,255	41,569	3,686	25,000
Field Service Payroll and related costs for two full-time field men and a director in 1967 plus two additional field men in 1968 Travel, telephone and miscellaneous	43,014	34,486	8,528	36,370
TOTALS	$534,030	$536,805	($2,775)	$561,470**

*The 1967 Budget was submitted and approved with the qualification that if the dues increase was approved, expenses would increase in proportion. This column adjusts the original 1967 Budget for the dues increase and for Budget Carry-Overs in Special Budgetary Provisions.

**This figure will be adjusted to the extent the Section on Ophthalmology grants a portion of their funds to underwrite some expenses. It is estimated, on the whole, income and expenses will break even.

State Medical Society of Wisconsin

MEMBERSHIP REPORT—DECEMBER 31, 1967

Totals by Classification

Regular	3,592	
Associate	89	
Affiliate	52	
Life	70	
Military	72	
Educational	31	
Career Appointment	20	
SUBTOTAL FULL-PAID MEMBERS		3,926
Resident		109
Honorary		7
Special Service		3
GRAND TOTAL		4,045

RECOMMENDATIONS OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended acceptance of Report No. 15 of the Council, and specifically recommended adoption of the proposed amendment of Chapter XI, Section 3 of the Bylaws.

HOUSE OF DELEGATES ACTION—Accepted Report No. 15 of the Council and adopted the proposed amendment of Chapter XI, Section 3 of the Bylaws as recommended by the Reference Committee.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON FINANCES—Reviewed the Proposed Operating Budget and commended the staff for the satisfactory results. It noted with pleasure the fact that there was no request for a raise in dues.

HOUSE OF DELEGATES ACTION—Accepted the Proposed Operating Budget as recommended by the Reference Committee.

MEMBERSHIP REPORT

State Medical Society of Wisconsin

MEMBERSHIP BY COUNTY

December 31, 1967

County Medical Society	Regular	Associate	Affiliate	Life	Military	Educational	Career Appointment	Subtotal Full-Paid Members	Resident	Honorary	Special Service	Grand Total
Ashland–Bayfield–Iron	17							17				17
Barron–Washburn–Sawyer–Burnett	31	1						32	3			35
Brown	125	1	1	4	4			135				135
Calumet	8							8				8
Chippewa	23							23	1			24
Clark	13	2						15				15
Columbia–Marquette–Adams	28	1		1				30	1			31
Crawford	9							9				9
Dane	421	12	5	8	17	16	6	485	26	3		514
Dodge	43	2		1				46				46
Door–Kewaunee	18			1				19				19
Douglas	21			1				22		1		23
Eau Claire–Dunn–Pepin	85	6		3				94	1			95
Fond du Lac	70			2	4			76				76
Forest	3		1	1				5				5
Grant	26	2		2				30				30
Green	42		1					43				43
Green Lake–Waushara	15	1		1				17				17
Iowa	8	1		1				10				10
Jefferson	30	1		2				33	1			34
Juneau	7							7				7
Kenosha	77		2	1			1	81	1		1	83
La Crosse	98	2	4	2	1			107	1		1	109
Lafayette	4		1					5				5
Langlade	12							12				12
Lincoln	14	1						15				15
Manitowoc	53			1				54				54
Marathon	65		2	1	1			69	1			70
Marinette–Florence	17	1		1				19	1			20
Milwaukee	1,214	33	18	17	26	15	11	1,334	62	3	1	1,400
Monroe	11	1					1	13				13
Oconto	8			1				9				9
Oneida–Vilas	26	2						28				28
Outagamie	88			1	3			92	1			93
Ozaukee	18							18	1			19
Pierce–St. Croix	28		2	1	1		1	33				33
Polk	22		1		1			24	1			25
Portage	28							28				28
Price–Taylor	12	1			1			14	1			15
Racine	116	1	4	5	3			129	1			130
Richland	11	1						12				12
Rock	107	3		2				112				112
Rusk	5							5				5
Sauk	20		5		1			26				26
Shawano	15	1						16				16
Sheboygan	71	3	2	2				78				78
Trempealeau–Jackson–Buffalo	20			2				22				22
Vernon	15	1			1			17				17
Walworth	27	3			1			31				31
Washington	26		1	1	1			29				29
Waukesha	126	1	1	1	2			131	4			135
Waupaca	17	1			1			19				19
Winnebago	92	3		2	3			100	1			101
Wood	86		1	1				88				88
TOTALS	3,592	89	52	70	72	31	20	3,926	109	7	3	4,045

■ SUPPLEMENTARY REPORT OF THE COUNCIL —May 1968

James C. Fox, MD, La Crosse, Chairman

The Council wishes to announce its annual election of members of the Commission on State Departments. Dr. T. W. Tormey, Jr. of Madison, was reelected General Chairman, and Dr. W. J. Egan of Milwaukee, Vice-chairman. These ten division chairmen were elected: Dr. George G. Stebbins, (now deceased), Madison, Division on Aging; Dr. D. A. Treffert, Fond du Lac, Alcoholism and Addiction; Dr. H. A. Anderson, Stevens Point, Chest Diseases; Dr. Meyer S. Fox, Milwaukee, Ear, Nose and Throat; Dr. John J. Suits, Marshfield, Handicapped Children; Dr. John R. Evrard, Milwaukee, Maternal and Child Welfare; Dr. Edward E. Houfek, Sheboygan, Nervous and Mental Diseases; Dr. P. A. Dudenhoefer, Elm Grove, Rehabilitation; Dr. J. C. H. Russell, Fort Atkinson, School Health; and Dr. J. V. Bolger, Jr., Waukesha, Division on Vision. (These are all reappointments except Doctor Houfek.)

A number of additional resolutions for consideration by the House are also transmitted by the Council with its endorsement:

RESOLUTION K on the shortage of nurses.
RESOLUTION L on swimming water contamination tests.
RESOLUTION M on health careers.
RESOLUTION N on allied health professions and paramedical personnel, proposed for introduction to the American Medical Association House of Delegates.

Also included is a status report on the Society's standing request for an updated opinion of the Attorney General on nontherapeutic sterilization, together with a proposed resolution for your consideration.

The Executive Committee and the Council both have accepted physician guidelines for highway accident blood alcohol testing, and forward them to the House. The Council also went on record supporting the introduction of legislation which would grant immunity to a physician who elects to administer tests for intoxication requested by a police officer.

The Council reports its endorsement of Resolution J by the Section on Pathology previously circulated to all members of the House.

Finally, the Council reports for the information of the House its approval of a statewide conference to discuss specific proposals for easing the shortage of physicians in Wisconsin. The Council is concerned that there has been much talk but little specific action in the past, and is looking for concrete steps to be taken to improve the supply and distribution of physicians and to attract and hold physicians in Wisconsin.

To be held this fall, the conference will include representatives of the State's two medical schools, the Board of Medical Examiners, the universities and colleges of Wisconsin, the Governor's Task Force on Medical Education, members of the Legislature, and others with a direct concern in the problem.

This, gentlemen, concludes the supplementary report of the Council.

I might also say in passing, although it does not make a great deal of difference, that as Chairman of the Council this is the last time I shall address you. Having been on the Council for many years, and with your permission and kindness, I have been Chairman of the Council for the last few years and I think it is time an old man like myself should get off and that you have someone in my place who probably has new ideas, who probably is more ambitious, and who probably can do the State Society much more good than I can.

As a consequence, I have asked the men in the Seventh Councilor District, of which I am a member, to elect someone else, and I am sure they will this year. Whether you like it or not you won't have to listen to me in the years to come as Chairman of the Council.

Perhaps to you this will be a great relief. To me it will be something that I shall miss; but I think all of us must recognize the fact that we must have the younger men in our State Society become much more active, not in the politics of the State Society but in the statesmenship of the State Society.

To me, "politics" sort of connotes a dirty word. You go around and hit this guy and that guy and the other guy, and you say, "I'll do this if you will do that," and so on. Fortunately this has never been a problem for me because you have been kind enough to allow me to be your Councilor. You have been kind enough to allow me to be the Chairman of the Council for several years. I don't claim any great fame as a consequence. I have tried to do the best I could, and the future will decide whether or not I did a good job.

The only message I want to leave with you is this: I want all of you to try to get the younger men in your county districts to become interested and to become part of the State Medical Society. We have many great organizations in our State. The Academy of General Practice is a tremendous organization. The Wisconsin Surgical Society is great also. Being an internist, I might look with a rather jaundiced eye on either one of them; but the Wisconsin Society of Internal Medicine, the Wisconsin Academy of Ophthalmology, Ear, Nose and Throat, Dermatology, all the way down the line, are great organizations.

Gentlemen, you know where the power lies—and it is in the State Medical Society of Wisconsin. Regardless of your affiliation in any particular group, if we are going to continue to practice medicine as free men, as free doctors, we must be active in our own Medical Society.

With the heavy hand of government coming in and squeezing all of us to its way of thinking, with the various organizations and health agencies, and so on, that are all interested in the health of the people of Wisconsin and of America, they all need direction; and the only direction they can get, and the best direction they can get, is from you, the policy-making organization of the State Medical Society.

Therefore, I would ask all of you to become more interested in what the State Medical Society is doing for you and in what you can do for the practice of medicine not only in the State of Wisconsin but in the nation as a whole.

I suppose many of you don't remember when, as Chairman of the Council, I had the privilege of administering the oath of office to our officers. The oath says, "I will pledge myself and my office to the duty of providing increasingly improved medical care to the people of the State of Wisconsin."

Gentlemen, that is all I ask you to do.

REPORT ON REQUEST TO ATTORNEY GENERAL FOR OPINION ON NONTHERAPEUTIC STERILIZATION

Mr. Robert B. Murphy, General Counsel

In the absence of any appellate decisions on the legality of nontherapeutic sterilizations in Wisconsin, the attorneys for the State Medical Society have followed the published opinions of the Attorney General of this state. These opinions have been consistently conservative, and have indicated the possible criminal and civil liability of a physician who

sterilized a patient for other than therapeutic reasons.

In recent years there has been an increase in statutes authorizing nontherapeutic sterilization. There has also been an increasing interest in the subject on the part of urologists and others. The Wisconsin Urological Society asked for a discussion at its May, 1966 meeting and I was authorized by the Society to make such a presentation. Its membership appeared to be divided, with some favoring statutory authorization and others favoring continued reliance on the opinions of the Attorney General.

Inasmuch as there had been no formal opinions expressed by the Attorney General's Office on the subject for nearly 30 years during which both medical and public opinion may have changed substantially, the State Board of Medical Examiners asked for an opinion in August, 1966. The Society authorized for cooperation of our office as the general counsel for the Society.

The request of the State Board of Medical Examiners, now known as the Medical Examining Board, was researched by staff members of the Attorney General's office in the fall of 1966 and a proposed opinion drawn. This proposed opinion was reportedly limited to the criminal liability question and did not discuss the possible civil liability of the surgeon who performed the procedure.

A representative of the Attorney General's staff told me on several occasions in late 1966 that he expected the opinion would be announced on time for inclusion in the January 1967 *Blue Book*. In anticipation of this possibility, the assistant editor of the *Blue Book* removed the article which had been published for several years, which summarized the earlier opinions of that office. Space for the anticipated new opinion was held as long as possible.

The Attorney General has continued to withhold approval of an opinion, and since it cannot be released without his sanction, it has not been published to date.

In an effort to expedite the publication of an opinion, I have made several visits to the Attorney General's office since November 1966, and probably a dozen phone calls.

In the summer of 1967, the Board of Medical Examiners again requested action through its secretary, Dr. T. W. Tormey, Jr. I asked him by telephone on May 8, 1968 whether he had ever received a reply or the opinion. He said he had no memory of an acknowledgment of his second request and that he had not received an opinion as of May 8.

The substance of this report was given the Council at its March 1968 meeting. It is now forwarded to the House as a summary of the efforts made during the past two years by both the Medical Examining Board and the State Medical Society to obtain an updated opinion from the Attorney General on the present legal status of nontherapeutic sterilization in this state. Below is a suggested resolution for the assistance of the House in the event it is deemed advisable to express a further position on this subject.

Resolution Relating to Nontherapeutic Sterilization

WHEREAS, the subject of nontherapeutic sterilization has assumed increasing importance to members of the public and to the medical profession in recent years; and

WHEREAS, there is an absence of reported court decisions or a statute on the subject in this state, and a corresponding dependency on published opinions of the Attorney General of Wisconsin, the most recent of which was issued in June, 1938; and

WHEREAS, the State Board of Medical Examiners made a request to the Attorney General of Wisconsin for an updated opinion on the subject in 1966, and failing receipt of such an opinion, made a similar request in 1967, and no such opinion has been received to date; be it

Resolved, by the House of Delegates of the State Medical Society of Wisconsin, in annual session assembled, that a communication be sent the Attorney General by appropriate officers of the Society indicating the importance of the requested opinion to concerned members of the public and of the medical profession as well, and that such communication urge the issuance of such an opinion without further delay.

PHYSICIAN GUIDELINES FOR HIGHWAY ACCIDENT BLOOD ALCOHOL TESTING

Introduction

No group is more closely involved in the tragic human toll caused by motor vehicle accidents than the medical profession. A major contributing factor to this toll is the driver who has been drinking. It is further aware that Wisconsin does not at this time have an implied consent law which would apply to all persons licensed to operate motor vehicles. It also knows of the heavy reliance of law enforcement officials on chemical tests for intoxication. The profession is, likewise, aware of its dual responsibilities as citizens and as physicians. Finally, it has been advised that the courts have settled some areas of the law relating to such chemical tests but that other areas remain unsettled.

In light of these considerations, and to permit the medical profession to fulfill its responsibilities to government as well as to those injured in traffic accidents, the House of Delegates adopts the guidelines which follow as an assistance to all physicians in the state who may be called on to take a blood sample by a law enforcement officer.

The guidelines are also based in part on the understanding that in the near future law enforcement officers throughout the state will have available to them equipment permitting the taking of chemical tests from an accused driver which do not require the services of a physician.

It is to be clearly understood that the guidelines apply only when all of the following facts are present:

a. The person to be examined has been injured in a motor vehicle accident and has been brought to a hospital or to a physician's office for examination and any needed treatment;

b. The injured person has been arrested on a charge growing out of driving while under the influence of an intoxicant. (It is the responsibility of the law enforcement officer to tell the physician that the injured person has been arrested); and

c. The officer *directs* the physician to take a blood sample from the injured person.

Recommended Guidelines

1. *Written Direction to Physician.* The physician should present to the officer a form similar to that attached and marked as "Form A," explaining that he will not proceed until the direction has been signed.

2. *Written Authorization from Injured Person.* Wherever possible, and if the physician believes the injured person has the capability of giving authorization, the physician should obtain the written authorization of the injured person by presenting for signature a form similar to that attached and marked as "Form B."

3. *Injured Person Willing but Unable to Write.* If the injured person is conscious, but unable to sign, and gives his oral consent to the taking of a blood sample, and in the physician's judgment is capable of giving consent, such facts should be noted by two witnesses, if at all possible.

4. *Injured Person Unconscious.* In this situation, the physician need not take a blood sample solely on the direction of the law enforcement officer. If he does take a blood sample in the course of his physical examination, its production as evidence may be required later.

5. *Injured Person Refuses Test.* It is a matter of professional judgment whether to proceed with the taking of a blood sample where the injured person refuses by words or by physical resistance to authorize the procedure.

6. *Cooperation With Law Enforcement Officers.* Working arrangements with local law enforcement agencies should be developed by local medical societies as rapidly as feasible. This would include the establishment of procedures for the preservation of blood samples for evidentiary use.

NOTES TO PHYSICIANS:

1. The physician may be called on to take a blood sample in a place other than a hospital or physician's office. The physician must decide whether, as a matter of professional judgment, such a place and its equipment meet acceptable hygienic standards. If not, he should not take the sample there.

2. Wherever feasible, the physician should encourage law enforcement officers to employ chemical tests other than those calling for the taking of a blood sample.

Form A

DIRECTION TO DRAW BLOOD

The undersigned, _____, a law enforcement officer of the state of Wisconsin, hereby directs _____, M.D., to draw blood from the accused, _____ _____. The undersigned arrested the accused at ___:___ ___.M. for alleged criminal acts involved in driving a motor vehicle while under the influence of an intoxicant, and the blood drawn will be used to perform a clinical test to determine his blood alcohol level, which may be used as evidence against him. The undersigned has informed the accused that he is under arrest, that this test will be conducted and its purpose.

Dated _____, at ___:___ ___.M.

Witnesses:

_____ _____
Name

_____ _____
Title

Form B

AUTHORIZATION FOR DRAWING BLOOD

The undersigned, _____, hereby consents to the drawing of blood from him by or under the direction of _____ _____, M.D. The undersigned understands that the blood is being drawn for the purpose of determining its alcoholic content, and that the results of this determination may be used in connection with his prosecution on criminal charges involving driving while under the influence of an intoxicant.

Dated _____.

Witnesses:

_____ _____*
Name

_____

* If unable to sign name, but capable of giving consent, so note in this blank and have witnesses sign as having witnessed his oral consent.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Reviewed the Supplementary Report of the Council except that portion dealing with physician guidelines on blood alcohol testing and the matter of legislative immunity, and recommended acceptance of the report. Noted that the proposed statewide conference on the shortage of physicians should also include discussions relative to any recommended improvements in the provision of medical care, and possibly discussions relative to reducing the cost of medical care.

HOUSE OF DELEGATES ACTION—Accepted the Supplementary Report of the Council as recommended by the Reference Committee.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended acceptance of the report by legal counsel on the request to the Attorney General for an opinion on nontherapeutic sterilization, and specifically recommended adoption of the resolution urging issuance of such an opinion.

HOUSE OF DELEGATES ACTION—Accepted the sterilization report and adopted the resolution as recommended by the Reference Committee.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended that the Physician Guidelines for Highway Accident Blood Alcohol Testing be adopted by the House and distributed to all members of the Society, and further recommended that the Council revise these guidelines from time to time as experience and circumstances may indicate.

HOUSE OF DELEGATES ACTION—Accepted the recommendations of the Reference Committee, and adopted the Physician Guidelines for Highway Accident Blood Alcohol Testing.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Extended special commendation to Doctor Fox for his many years of valuable service to the Council of the Society and as its chairman. Although Doctor Fox received a standing ovation at the conclusion of his report, the Reference Committee deemed it a special privilege to formalize the obvious appreciation of the entire membership of the House.

HOUSE OF DELEGATES ACTION—Accepted the commendation of the Reference Committee.

Report No. 16

■ REPORT OF DIVISION ON NERVOUS & MENTAL DISEASES—May 1968

A. A. LORENZ, MD, Eau Claire, Chairman
E. E. HOUFEK, MD, Sheboygan, Vice-chairman
J. T. PETERSIK, MD, Oshkosh
G. B. TYBRING, MD, Madison
HENRY VEIT, MD, Milwaukee
JEAN P. DAVIS, MD, Milwaukee
KEITH M. KEANE, MD, Appleton
T. J. NEREIM, MD, Madison
CHARLES A. WUNSCH, MD, Wauwatosa
OTTO A. DITTMER, MD, Ripon
LeROY A. ECKLUND, MD, Madison
FRANCIS M. FORSTER, MD, Madison
WILLIAM H. HEYWOOD, MD, Marshfield

Two meetings of the Division have been held since last reporting. One was held on Oct. 15, 1967, and the second on Mar. 24, 1968—both at the State Medical Society building in Madison. Another meeting is scheduled on June 9, 1968.

In its previous report, the Division informed the Commission on State Departments and the House concerning the formation of Mental Health Committee of the Legislative Council pursuant to J.R. 34, S. with its charge being to study all present

state laws relating to the mentally ill, deficient and infirm with a view to systematic and unified codification and to develop such information as will enable the legislature to provide more adequately and efficiently for the protection, health and welfare of these citizens of the state—and that Doctor Petersik had been named as the Division's representative on that Committee. He continues to serve in this capacity although perhaps it is appropriate to relate that this has been reconstituted as the Mental Health Advisory Committee to the Legislative Council Committee on Public Welfare.

Several attempts have been made to rewrite Chapter 51, the Mental Health Act, and the draft circulated under date of Mar. 22, 1968, would equate a clinical psychologist with a physician with regard to the certification of need for either a voluntary admission or an involuntary commitment of a patient to a mental health facility.

In view of this development, the Division adopted the following statement at its Mar. 24, 1968 meeting and submits it for approval as official SMS policy:

> "Mental illness is the resultant of many forces, including genetic, constitutional, congenital, chemical, functional, cultural, environmental, various disease processes (brain tumor, neurological diseases), etc., which produce disorders in an individual for which medical diagnosis and treatment is and always has been the appropriate agent.
>
> "The commitment procedure conceptually is an attempt via statute to define and meet medical treatment needs for a sick person and not solely for the health and safety of the community.
>
> "The diagnosis and recommendation of treatment procedures for sick individuals, including those who are mentally ill, is the responsibility of the medical practitioner; although various aspects of diagnosis and treatment can be delegated to other disciplines. However, total care and responsibility rests primarily with the physician who alone holds an unlimited license to care for sick people."

The foregoing is in reaffirmation of a previous recommendation of the Division—"that any contemplated revision of Chapter 51 regarding commitment procedures, such commitments shall be based upon certification of a duly licensed physician —preferably a psychiatrist."

Recognizing the importance of protecting the rights of patients while at the same time endeavoring to assure the type of care in keeping with the changing needs of patients, Doctor Petersik has been named as Chairman of the Division's Subcommittee on Commitment Laws and two additional physicians have been named to serve that Subcommittee in an advisory capacity.

Communications between those physicians engaged primarily in the mental health field and the non-psychiatric practitioners continues to be a problem. However, in augmenting the talents of the Subcommittee on Commitment Laws, by continuing for the time being the Ad Hoc Committee on County Hospitals and through increased allocation of staff time (a long time recommendation of the Division) which contemplates additional staff support to all the scientific sections of the Society, the Division anticipates improved liaison with all segments of the mental health team. As an added measure, in this regard, the Division voted that the delegate to the Section on Neurology and psychiatry be made a special invitee to all Division meetings.

With regard to a continuation of the function for which the former Mental Health Advisory Committee was originally created—and due to a typographical error in the Proceedings of the 1967 Annual Session—the Division wishes to restate its recommendation of a year ago as follows:

> "Irrespective of the agency which might be developed or designated to continue the functions contained in the original concept of the Mental Health Advisory Committee, it is the consensus of the Division that the following should be stressed:
>
> A. Need for and importance of coordinated planning of health and welfare programs.
> B. Essentiality of non-governmental voice in programming and planning; including both medical and general citizen representation.
> C. Opinion that an Inter-agency Committee on Health and Welfare could not perform the functions outlined in the original concepts of the Mental Health Advisory Committee.
> D. Medical (SMS) support for good mental health programs and facilities.
>
> "Moreover, since the SMS was among the forerunners in developing the original Advisory Committee, its advice should be sought on a continuing basis—preferably via the medium of appropriate physician membership representation on any committee charged with the responsibility in this important area of activity."

The Division has received information to the effect that some county welfare departments may be referring Title XIX (Medicaid) beneficiaries to sources of mental health care. Such direct referrals would appear to be in violation of the "free choice" provisions of the Wisconsin enabling legislation. Accordingly, the State Department of Health and Social Services has been requested to contact county welfare directors and remind them of the provision that "Any person eligible for medical assistance under ss. 49.46 and 49.47 may be entitled to use the physician, dentist, pharmacist, hospital, skilled nursing home or other provider of care which he has designated as his choice, . . ." to the end that the principle of free choice of source of authorized health care shall be maintained as intended by the legislation.

Again this year, the Division contemplates the sponsorship of a scientific symposium. A subcommittee has been requested to develop the program format, secure the necessary clearances from the Commission on Scientific Medicine and get credit approval from the American Academy of General Practice. Preliminary plans call for the symposium to be held in September and at a location other than Eau Claire—probably in Marshfield. As more details are developed, it is anticipated that the general membership will be informed as it has been in the past.

The Division continues in its desire to further the efforts of effective mental health programs at all levels under appropriate medical guidance and responsibility and to that end it welcomes both the cooperation of and constructive suggestions from all other elements within the State Medical Society.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance as official policy of the State Medical Society the recommendation of the Division with respect to the statement it adopted on Mar. 24, 1968. It further suggested adoption of all other recommendations contained in the report of the Division, and commended it for its past and continuing efforts in the special field of mental health as well as the positive aspects of health generally.

HOUSE OF DELEGATES ACTION—Accepted the report of the Division on Nervous and Mental Diseases as recommended by the Reference Committee.

■ RESOLUTION A—May 1968

Introduced by: Richland County Medical Society

Re: GENERAL PRACTICE

WHEREAS, The members of the Richland County Medical Society have become acutely aware of the shortage of General Practitioners in the State of Wisconsin and the nation as a whole; and

WHEREAS, We feel that a prominent cause of the shortage of the General Practitioner is due to the direction taken by teaching institutions in general, the University of Wisconsin and Marquette Medical Schools in particular; therefore be it

Resolved, That we would like to see established a chair of general practice on the staff of the two mentioned medical schools and a general practice residency or a rotating internship at the involved hospitals, in order to more clearly direct the schools to a more general field of medical teaching than is now obtained with the emphasis on specialties.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended adoption of Resolution A in the following modified form:

"WHEREAS, The members of the State Medical Society of Wisconsin have become acutely aware of the shortage of general practitioners in the State of Wisconsin and the nation as a whole, and

"WHEREAS, we feel that a prominent cause of the shortage of general practitioners is due to the direction taken by teaching institutions in general, the University of Wisconsin and Marquette Medical Schools in particular; therefore, be it

"Resolved: That the State Medical Society of Wisconsin recommend that the aforementioned medical schools implement their plans for divisions of comprehensive medical care in consultation with the Wisconsin Academy of General Practice and the Section on General Practice of the State Medical Society of Wisconsin; and be it further

"Resolved: That the preceptorship programs be reexamined to include the use of more practicing general practitioners, singly or in groups."

HOUSE OF DELEGATES ACTION—Adopted the modification of Resolution A as recommended by the Reference Committee.

■ RESOLUTION B—May 1968

Introduced by: La Crosse County Medical Society

Re: MARQUETTE MEDICAL SCHOOL

WHEREAS, The Marquette Medical School has had continuous difficulty in raising funds for an adequate program; and

WHEREAS, The State of Wisconsin suffered a loss in practicing physicians in 1967 as compared with 1966; and

WHEREAS, More graduates of Marquette's Medical School practice in this state than those of any other medical school; therefore be it

Resolved, That the State of Wisconsin acquire the Marquette Medical School to be integrated with the University of Wisconsin at Milwaukee as one of its divisions.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended the following substitute for Resolution B:

"WHEREAS, the State of Wisconsin suffered a loss in practicing physicians in 1967 as compared with 1966, and

"WHEREAS, the Governor's Task Force on Medical Education has recommended that (1) the University of Wisconsin at Madison expand its medical school admission enrollment to 160; (2) the Marquette School of Medicine continue and expand its admission enrollment to 160; and (3) planning be undertaken relative to a third medical school; therefore, be it

"Resolved: That the State Medical Society of Wisconsin urge the State of Wisconsin to approve the recommendations of the Governor's Task Force on Medical Education and to aid the continued operation of the Marquette School of Medicine with State funds."

HOUSE OF DELEGATES ACTION—Adopted substitute Resolution B as recommended by the Reference Committee and amended by the House to include the word "admission" prior to the word "enrollment" in both clauses in the second Whereas.

■ RESOLUTION C—May 1968

Introduced by: La Crosse County Medical Society

Re: REDISTRICTING

WHEREAS, The House of Delegates in 1964 appointed a special committee to study redistricting; and

WHEREAS, The Council has not been redistricted; therefore be it

Resolved, (1) That the Council of the State Medical Society correspond to the Congressional Districts of the State of Wisconsin to be changed each time the Districts are changed by the State Legislature, and

(2) That candidates may be nominated either by a nominating committee or by a petition of ten members of the District, and

(3) That if a member of the society cannot attend a meeting at which a councilor is to be elected, he may request a ballot to be mailed to the secretary before that meeting, and

(4) In metropolitan areas where a member may reside in one District and practice in another, that he be required to select the District in which he votes for a councilor.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended that Resolution C be rejected since it would serve no useful purpose.

HOUSE OF DELEGATES ACTION—Rejected Resolution C.

■ RESOLUTION D—May 1968

Introduced by: La Crosse County Medical Society

Re: ANNUAL MEETING LOCATIONS

Resolved, That the State Medical Society rotate its annual meetings to Madison, La Crosse, and Green Bay, along with Milwaukee.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Noted that the principle expressed in Resolution D, of rotating annual meetings, is excellent, but its acceptance would necessitate added cost to the membership either in registration fees or an increase in dues to offset a reduction in exhibit income. Accordingly, it recommended that action be postponed at this time.

HOUSE OF DELEGATES ACTION—Accepted recommendation of Reference Committee and rejected Resolution D.

■ RESOLUTION E—May 1968

Introduced by: Racine County Medical Society

Re: COMPULSORY IMMUNIZATION LAWS

WHEREAS, We live in an era of unprecedented good health and longevity; and

WHEREAS, It is widely accepted that the ravages of Small Pox, Diphtheria, Tetanus, Whooping Cough, Poliomyelitis, Measles, and other diseases have been

diminished or obliterated by immunization which has thereby contributed materially to optimum health and longevity; and

WHEREAS, While the majority of the States have compulsory immunization laws, the progressive State of Wisconsin does not have such legislation and as a consequence large numbers of children do not have such protection before school age; therefore be it

Resolved, That the State Medical Society of Wisconsin, through its House of Delegates duly assembled, encourage the Legislature of the State of Wisconsin, in the best interests of its citizens, to enact such compulsory immunization laws.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Acknowledged its sympathy with the spirit of Resolution E, but recommended rejection because of its compulsory component, and further recommended that every effort be made by the State Medical Society and the component county medical societies to educate the general public to the values of immunization.

HOUSE OF DELEGATES ACTION—Following considerable discussion as to the merits of compulsory immunization, the recommendations of the Reference Committee were accepted and Resolution E was rejected.

■ RESOLUTION F—May 1968

Introduced by: Racine County Medical Society

Re: SMS PHYSICIANS GROUP—WPS

WHEREAS, Under the present Group Medical Insurance Coverage Plan of the State Medical Society of Wisconsin, no coverage is provided for the widow and dependent children of a deceased physician; and

WHEREAS, It is desirable that such insurance protection be made available to the widow and dependent children of a deceased physician; therefore be it

Resolved, That the State Medical Society of Wisconsin, through its House of Delegates duly assembled, does hereby urge and recommend that the Group Coverage provided by Wisconsin Physicians Service be extended to provide adequate group medical insurance coverage for the widow and dependent children of a deceased physician.

RECOMMENDATION OF REFERENCE COMMITTEE ON FINANCES—Based on advice of the Society's actuary, Mr. Carl Tiffany, that such extension would not materially affect the overall cost and, more importantly, on what is felt to be an obligation to "care for our own," the Reference Committee concurred in the recommendation to provide insurance protection to such widows and dependent children as may request it.

HOUSE OF DELEGATES ACTION—Adopted Resolution F as recommended by the Reference Committee.

■ RESOLUTION G—May 1968

Introduced by: Douglas County Medical Society

Re: DIPLOMA NURSING SCHOOLS

WHEREAS, There is a continuing and increasing deficit of registered nurses to adequately staff the existing and expanding health facilities; and

WHEREAS, Statewide and nationwide no program for improving this important necessity exists; and

WHEREAS, The American Medical Association has gone on record recommending an increase in Diploma Nursing Schools; therefore be it

Resolved, That the State Medical Society of Wisconsin go on record favoring these schools; and be it further

Resolved, That the State Medical Society of Wisconsin offer all possible encouragement and help to all communities seeking to establish such schools.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended retention of the "Whereas" clauses and substitution of a single "Resolved" as follows:

"*Resolved*, That the State Medical Society of Wisconsin offer all possible encouragement and help to all communities seeking to establish such schools, and encourage nursing education at all levels, including degree schools, diploma schools, and schools for licensed practical nurses."

HOUSE OF DELEGATES ACTION—Adopted Resolution G as amended by the Reference Committee.

■ RESOLUTION H—May 1968

Introduced by: Waukesha County Medical Society

Re: IMPLIED CONSENT LAWS

WHEREAS, In the past 20 years there has been a progressive increase in the highway death toll despite improvements in highways, automobile function, auto safety devices, safety instruction and driver training, increased numbers of local, county and state traffic monitors and law enforcement personnel; and

WHEREAS, The physicians of Waukesha County, in their experiences in treatment of all kinds of automobile accidental injuries of lethal and nonlethal nature, have been impressed that a high percentage of such cases (not authenticated because of legal and medico-legal prohibition) are, and have been, in our estimation definitely associated with excessive intake of alcohol; therefore be it

Resolved, That the State Medical Society of Wisconsin as a unit

(a) go on record as openly supporting passage of laws dealing with implied consent for testing of blood alcohol level and drug intoxication, and

(b) take an active part in encouraging our state legislators to formulate and pass such laws.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Considered Resolution H and recommended that the following be substituted:

"WHEREAS, in the past twenty years there has been a progressive increase in the highway death toll despite improvements in highways, automobile function, auto safety devices, safety instruction and driver training, increased numbers of local, county and state traffic monitors and law enforcement personnel, and

"WHEREAS, physicians, in their experiences in treatment of all kinds of automobile accident injuries of lethal and non-lethal nature, have been impressed that a high percentage of such cases are and have been in our estimation definitely associated with the intake of alcohol; therefore, be it

"*Resolved*: That the State Medical Society of Wisconsin (a) reaffirm its earlier stated position of support of the principle of legislation establishing implied consent for the performance of chemical tests on persons arrested for driving motor vehicles while under the influence of intoxicants; (b) support legislation conferring appropriate immunity to a physician who administers chemical tests for intoxication at the request or direction of a law-enforcement officer; (c) actively encourage State legislators to enact such laws at the 1969 session."

HOUSE OF DELEGATES ACTION—Accepted the recommendation of the Reference Committee and adopted Resolution H as amended.

■ RESOLUTION I—May 1968

Introduced by: Waukesha County Medical Society

Re: BLOOD ALCOHOL TESTS

WHEREAS, An opinion has been rendered by our State Attorney General that members of our state, county and local law enforcement agencies have authority to "order" a physician to draw blood from an individual for purposes of alcohol determination either with or without said individual's permission, and failure to comply with this order constitutes an illegal act and makes a physician subject to arrest and prosecution; and

WHEREAS, It is the opinion of the legal advisor to our State Medical Society that at present there is no law in the State of Wisconsin specifically dealing with the aforementioned situation and/or protecting the physician in said situation and hence in complying with said police order a physician may become subject to suit for assault; therefore be it

Resolved, That the State Medical Society of Wisconsin take such action as is necessary enjoining any law enforcement officer from ordering any physician to draw blood from an individual against the wishes of said individual until the legality of the order and consequences of compliance with such an order are clarified.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended rejection of Resolution I for the reason that the rephrasing of Resolution H incorporates the intent of Resolution I, and for the further reason that the action requested of the State Medical Society cannot be implemented under existing laws.

HOUSE OF DELEGATES ACTION—Accepted recommendation of Reference Committee and rejected Resolution I.

■ RESOLUTION J—May 1968

Introduced by Section on Pathology

Re: PRACTICE OF PATHOLOGY

WHEREAS, The specialty of pathology is a branch of medicine recognized by the American Medical Association and the State Medical Society of Wisconsin; and

WHEREAS, The specialty of pathology is legally considered to be the practice of medicine in the State of Wisconsin; and

WHEREAS, Pathologists in Wisconsin have a license to practice medicine and surgery; and

WHEREAS, Section 1801. Title XVIII of Public Law 89–97 specifically forbids federal supervision or control of the practice of medicine; and

WHEREAS, The practice of pathology is a consultative branch of medicine; and

WHEREAS, The "Conditions for Participation of Hospitals in Health Insurance for the Aged" states on page 11 (Medical Staff IV, Standard B, Factor 1): "Routine procedures such as x-ray examination, electrocardiogram determination, tissue examination, and proctoscopic and cystoscopic procedures are not normally considered to be consultations"; and

WHEREAS, The "Condition for Participation of Hospitals" further states on page 26 (Standard H, Factor 6): "Arrangements for tissue examinations done outside the hospital are made with a laboratory which is certified to provide this service for the Health Insurance for the Aged Program"; and

WHEREAS, The "Conditions for Coverage of Independent Laboratories for Health Insurance for the Aged" on page 1 (Introduction) includes this acceptable definition: "Consultation is a deliberation of two or more physicians with respect to the diagnosis or treatment in any particular case"; and

WHEREAS, The definition further continues in a contradictory vein: "Consultation, as distinguished from providing clinical laboratory services, includes history taking, examination of the patient and, in each case, transmitting to the attending physician an opinion concerning diagnosis and/or treatment"; and

WHEREAS, Pathologists are consultant physicians who consult *only* with other physicians in regard to diagnosis and/or treatment; therefore be it

Resolved, That the State Medical Society of Wisconsin inform the Medicare Division of the Division of Health, Department of Health and Social Services of the State of Wisconsin, and the Federal Medicare Intermediary of Wisconsin Physicians Service, that the services of pathologists are physician's services; and be it further

Resolved, That the State Medical Society of Wisconsin take such action as is necessary to ensure that the Health Insurance for the Aged regulations be clarified, as they are in part contradictory to the practice of medicine in the State of Wisconsin; and be it further

Resolved, That the State Medical Society of Wisconsin request that the Division of Health, Department of Health and Social Services of the State of Wisconsin, as the certifying agency for Health Insurance for the Aged in Wisconsin, provide such certification to pathologists as is necessary to ensure that eligible Medicare patients be reimbursed for pathologists' services without attempts at supervision and/or control over the physician's practice; and be it further

Resolved, That the State Medical Society of Wisconsin be prepared for further attempts on the part of the federal government to fragment and redefine the practice of medicine in its continuing efforts to control our profession.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended acceptance of the ten "Whereases" and the first two "Resolved" clauses, and substitution of a final "Resolved", in place of the last two "Resolved" clauses as follows:

"*Resolved*: That the Council on Health and the Division of Health be requested to evaluate the effect and precedent of regulations of the Department of Health, Education and Welfare that do not accommodate special situations such as the Consultant Physicians in Pathology present, and take appropriate action to attempt to secure an amendment to permit a group of consulting physicians to be recognized as are other physicians."

HOUSE OF DELEGATES ACTION—Adopted Resolution J as modified by the Reference Committee.

■ RESOLUTION K—May 1968

Introduced by: The Council for Clark County Medical Society

Re: SHORTAGE OF NURSES

WHEREAS, The State of Wisconsin is grievously short of trained nursing personnel; and

WHEREAS, The existing status pertaining to the licensing of nurses greatly hinders the recruitment of qualified nurses trained outside the State of Wisconsin; therefore be it

Resolved, That the State Medical Society of Wisconsin take action to urge the legislature to modify the existing laws pertaining to nurses so as to facilitate the recruitment and employment of well qualified out-of-state nurses.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended acceptance of Resolution K with amendment of the "Resolved" as follows:

"Resolved, That the State Medical Society of Wisconsin recommend modification of existing laws pertaining to nurses' credentials so as to facilitate the recruitment and employment of well-qualified out-of-state nurses."

HOUSE OF DELEGATES ACTION—Adopted Resolution K as amended by the Reference Committee.

■ RESOLUTION L—May 1968

Introduced by: The Council for Seventh Councilor District

Re: SWIMMING WATER CONTAMINATION TESTS

WHEREAS, The E-coli test for bacterial contamination of swimming areas has been shown to be inaccurate in determining water contaminated from skin or respiratory bacteria; and

WHEREAS, The State of Wisconsin Division of Health is using this as its criteria in contamination; and

WHEREAS, The Division of Health has failed to use other criteria such as Staphylococcal Index for swimming water; therefore be it

Resolved, That the House of Delegates recommend to the Council on Health that it study the situation and report to the Council of the State Medical Society.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Proposed the following substitute resolution for Resolution L:

"WHEREAS, the E-coli test has been shown to demonstrate only one form of swimming water contamination and fails to demonstrate skin or respiratory bacterial contamination, and

"WHEREAS, the State of Wisconsin Division of Health is using this test as its sole criterion in contamination; therefore, be it

"Resolved, That the House of Delegates of the State Medical Society of Wisconsin recommend to the Council on Health that it study the use of the Staphyloccal Index or any other suitable test for swimming water contamination and report to the Council of the State Medical Society."

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee's substitute resolution instead of Resolution L.

■ RESOLUTION M—May 1968

Introduced by: The Council for Third Councilor District

Re: HEALTH CAREERS

WHEREAS, The privileges of receiving and rendering medical services, available to all without regard for race or creed, require fair representation of all races and creeds within the medical community; and

WHEREAS, The need for health personnel of all types is rapidly increasing; therefore be it

Resolved, That the State Medical Society of Wisconsin:

1. Encourage all persons interested in health occupations to pursue training for their selected careers;
2. Welcome all persons now qualified for medical careers to all aspects of health care provisions, whether provided in hospitals or private offices;
3. Encourage all individual members and county medical societies of Wisconsin to embrace the above expressions;
4. Recommend the establishment of health career scholarship funds for members of minority groups not adequately represented in the medical community.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended acceptance of Resolution M with the following exception: That point 4 of the "Resolved" clause be amended to recommend the investigation of existing scholarship funds for members of minority groups not adequately represented in the medical community.

HOUSE OF DELEGATES ACTION—Adopted Resolution M with the amendment as recommended by the Reference Committee.

■ RESOLUTION N—May 1968

Introduced by: Wisconsin Delegation, AMA

Re: ALLIED HEALTH PROFESSIONS AND PARAMEDICAL PERSONNEL

WHEREAS, There is a recognized need to increase the number of persons trained in the health professions; and

WHEREAS, There are new and emerging paramedical health care occupations which, under proper conditions, have the potential of contributing to the total health care effort thereby increasing the efficiency of physicians; and

WHEREAS, The Council on Allied Health Professions and Services has recognized the need to identify and define both the existing and emerging groups now engaged in activities related to health care; and identify and delineate those areas in which persons who are not physicians may contribute to the total effort in health care; therefore be it

Resolved, That the AMA program of identification and delineation include designations of the privileges and responsibilities as well as the limitations of each category of paramedical personnel with respect to such matters as:

(a) licensure, registration or certification;
(b) privileged communications;
(c) standards of legal responsibility;
(d) hospital privileges;
(e) patient records; and
(f) other factors that have an important bearing on the patient-physician relationship in the interest of health care of high quality; and be it further

Resolved, That the AMA establish guidelines for the benefit of constituent and component organizations in dealing with new, as well as emerging paramedical disciplines as they come into being.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended acceptance of Resolution N as presented, with the understanding that it will be forwarded to the House of Delegates of the American Medical Association.

HOUSE OF DELEGATES ACTION—Adopted Resolution N as recommended by the Reference Committee.

■ INFORMATIONAL REPORT OF EXECUTIVE COMMITTEE OF BOARD OF TRUSTEES: CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION —May 1968

W. D. Stovall, MD, Madison, President

The Executive Committee of the Board of Trustees of the Charitable, Educational and Scientific Foundation, Inc. of the State Medical Society (CESF) has adopted the pattern of routinely filing

an informational report with the House of Delegates at each session. Since the majority of the programs of the CESF are of a continuing nature, the basic purpose of this report is to update and to review some of the activities undertaken during the past few months.

The Executive Committee, with the approval of the Board of Trustees, has created three ad hoc subcommittees to review some of the guidelines for basic operations of the CESF. Those committees appointed included a group to study and develop mechanisms for accepting and granting future scholarship and loan funds. Also a fund raising committee was appointed to devise a method of obtaining additional contributions from individuals and corporations. A bylaw committee was also appointed to review and make recommendations to the Board of Trustees.

The proposals of all of these committees will be considered by the Executive Committee and the Board of Trustees at the 1968 Annual Meeting of the CES Foundation.

We are continuing to make contacts with other associations and Wisconsin industries for the presentation of educational exhibits and programs. During the past year, the exhibit tracing the history of tuberculosis control was completed (details appeared in the May issue of the *Wisconsin Medical Journal* at page 28.) and is presently being featured at the Museum of Medical Progress and Stovall Hall of Health (MMP-SHH). When not on exhibit at the MMP-SHH, the Wisconsin Anti-Tuberculosis Association exhibit is available for loan to organizations throughout the state. Other loan exhibits which have been made available to organizations include the Transparent Twins, the exhibit tracing the development of the stethoscope and the medical paintings of Aaron Bohrod.

Another project which achieved success last year was the collection of funds to provide for the construction of an old time physician's office at Stonefield. A check for $6,000.00 was presented to the Board of Curators of the Wisconsin State Historical Society to enable the medical profession to be adequately represented at the Historical Society's Stonefield Village at Cassville, Wisconsin. The money for this project was raised by the CESF with the assistance of the Woman's Auxiliary to the State Medical Society. The Executive Committee takes this opportunity to once again thank the Auxiliary for their efforts in behalf of the CESF sponsored project.

The Foundation has continued its policy of administering not only funds which were donated to it for the purpose of student loans and grants, but also administering funds for many county societies and individuals who have provided funds for special purposes. For example, a recent fund was established for the purpose of recognizing an outstanding medical school senior from both the University of Wisconsin and Marquette Medical Schools. This fund will be known as the J. H. Houghton, M.D. Medical Student Award Fund and the first recipients will be announced during the 1968 Annual Meeting of the State Medical Society.

In the area of scholarship and loan funds, the Board of Trustees has authorized the removal of certain restrictions which were initially placed on funds. This is because at the present time some of the funds are not being used because of restrictions on residence, etc. It is the feeling of the members of the Board of Trustees that individuals studying medicine and fields ancillary to medicine should be eligible for receiving aid if funds are available and have not been used because of certain restrictions. Such restrictions are to be removed with the advance approval of the county medical societies and other donors who made the original funds available.

The Foundation has also approved the granting of a CESF Award to an individual who has made an outstanding contribution to the scientific, charitable and educational purposes of our organization. It is anticipated that the award will be given to both individuals and corporations. The first award will be given during the 1968 Annual Meeting of the CESF Board of Trustees.

Another project of the Foundation which has received support from the Wisconsin Legislature and several other state medical societies is the proposed issuance of a United States postage stamp to commemorate the medical work of William Beaumont, M.D. The Joint Resolution, as passed by the Wisconsin Legislature, appears below.

To demonstrate the Foundation's recognition of the importance of our medical history, the grave of Harmon Van Dusen, M.D., a past president of the State Medical Society, was appropriately marked and rededicated in October of 1967. Such projects call to the attention of both the profession and the public the great heritage of medicine.

The Museum of Medical Progress and Stovall Hall of Health opened on April 14 for the 1968 exhibit season and many new exhibits and displays are being planned. The Executive Committee continues to supervise the overall activities of the MMP-SHH and records with pleasure that since the last meeting of the House, the 100,000th visitor has toured the exhibits at Prairie du Chien. The Executive Committee urges every physician to visit the MMP-SHH and to tell his friends and neighbors of this project. This collection of memorabilia and displays pertaining to medicine's past and future, plus other contributions support many of the activities which translate the concern of medicine for making public health information available.

STATE OF WISCONSIN

SENATE JOINT RESOLUTION 71

June 9, 1967—Introduced by COMMITTEE ON LEGISLATIVE PROCEDURES, by request of Senators Bice and Warren and Assemblyman Lewison.

Memorializing the U. S. Post Office Department to issue a stamp commemorating Dr. William Beaumont.

WHEREAS, Doctor William Beaumont, a military surgeon, in and after 1822 conducted pioneering experiments in the physiology of digestion, which experiments form the basis of our present day knowledge of the digestive process; and

WHEREAS, these experiments were conducted by Doctor Beaumont at Fort Crawford, Prairie du Chien, Crawford County, Wisconsin; and,

WHEREAS, the work of Doctor Beaumont and his contributions to man's welfare are deserving of honor and remembrance; and,

WHEREAS, the year 1972 will mark the 150th anniversary of the start of Doctor Beaumont's historic experiments; now, therefore, be it

Resolved by the senate, the assembly concurring, That the legislature of the state of Wisconsin proposes and respectfully requests that in 1972 the United States Post Office Department issue a Beaumont commemorative stamp to honor the great American physician, Doctor William Beaumont; and, be it further

Resolved, That properly attested copies of this resolution be sent to Lawrence O'Brien, Postmaster General of the United States, to the secretary of the United States Senate and the chief clerk of the House of Representatives and to each member of the Congress from Wisconsin.

All activities, programs and projects of the CES Foundation are considered by the Board of Trustees which is made up of a representative from every County Medical Society and all Councilors and Officers of the State Medical Society. Proceedings of the Board of Trustees 1968 Annual Meeting will be made available to all members of the Society.

Contributions by individuals, physicians, county medical societies, corporations and interested sponsors are listed below in Exhibit A.

Exhibit A

Contributions to the Charitable, Educational and Scientific Foundation

BY MEMBERS OF COUNTY MEDICAL SOCIETIES

January 1, 1967–December 31, 1967

County	Regular Members	Voluntary Contributions in Response to Billing		Additional Contributions, Memorials, "In Honor of," Ear Marked, Etc.	
		Number	Amount	Number	Amount
Ashland-Bayfield-Iron	17	16	$ 160.00		$ 10.00
Barron-Washburn-Sawyer-Burnett	31	27	270.00		
Brown	125	86	860.00		
Calumet	8	6	60.00		
Chippewa	23	19	190.00		
*Clark	13	10	100.00		
*Columbia-Marquette-Adams	28	20	200.00		20.00
*Crawford	9	9	90.00		10.00
*Dane	421	280	2,810.00	4	565.00
Dodge	43	26	260.00		5.00
Door-Kewaunee	18	9	90.00		
Douglas	21	13	130.00		25.00
Eau Claire-Dunn-Pepin	85	55	550.00		
Fond du Lac	70	59	590.00		215.00
Forest	3	1	10.00		
Grant	26	27	270.00		
Green	42	8	80.00	1	15.00
Green Lake-Waushara	15	13	130.00		
*Iowa	8	5	50.00		20.00
Jefferson	30	24	250.00	1	25.00
Juneau	7	4	40.00		
*Kenosha	77	66	670.00		25.00
La Crosse	98	71	710.00		45.00
Lafayette	4	2	20.00		
Langlade	12	10	100.00		30.00
Lincoln	14	13	130.00		
Manitowoc	53	20	200.00		
Marathon	65	38	380.00		
Marinette-Florence	17	17	170.00		
Milwaukee	1,214	662	6,670.00	5	2,169.00
Monroe	11	7	70.00		
Oconto	8	9	90.00		
Oneida-Vilas	26	19	190.00		
Outagamie	88	65	650.00		
Ozaukee	18	11	110.00		70.00
*Pierce-St. Croix	28	19	190.00		
Polk	22	15	150.00		
Portage	28	23	230.00		
Price-Taylor	12	13	130.00		
Racine	116	85	840.00	1	135.00
Richland	11	3	30.00		
Rock	107	64	640.00	1	35.00
Rusk	5	5	50.00		
Sauk	20	17	170.00		
Shawano	15	11	110.00		
Sheboygan	71	32	320.00	1	25.00
Trempealeau-Jackson-Buffalo	20	20	200.00		10.00
Vernon	15	16	160.00		
Walworth	27	21	210.00		
Washington	26	21	210.00		
Waukesha	126	100	1,040.00		25.00
Waupaca	17	15	150.00		
Winnebago	92	66	660.00		100.00
Wood	86	11	110.00	1	115.00
	3,592	2,284	$22,950.00	15	$3,694.00

*See Contributions By County Medical Societies.

NOTE: In several Counties the number of members making voluntary contributions exceeds the regular members, because members in classifications other than regular also contributed during the year.

Contributions by

MEDICAL SOCIETIES

	Amount of Contribution
State Medical Society of Wisconsin	$ 3,435.00
Clark County Medical Society	100.00
Columbia-Marquette-Adams County Medical Society	500.00
Crawford County Medical Society	500.00
Dane County Medical Society	125.00
Iowa County Medical Society	50.00
Kenosha County Medical Society	2,500.00
Pierce-St. Croix County Medical Society	25.00
Woman's Auxiliary to State Medical Society	312.50
Woman's Auxiliary to Dane County Medical Society	100.00
Woman's Auxiliary to La Crosse County Medical Society	10.00
Woman's Auxiliary to Marathon County Medical Society	10.00
Woman's Auxiliary to Ozaukee County Medical Society	30.00
Woman's Auxiliary to Sheboygan County Medical Society	102.00
	$ 7,799.50

Contributions by

OTHER ORGANIZATIONS AND INDIVIDUALS

	Amount of Contribution
American Cancer Society	$ 82.00
ARPS Corporation	50.00
CIBA Corporation	500.00
Clinic of Internal Medicine, Milwaukee	100.00
Eli Lilly Company	250.00
Hoffmann La Roche, Inc.	750.00
Jackson County Federation of Womans' Clubs	10.00
Janesville Medical Center	25.00
Kohler Company	500.00
La Crosse Clinic, Ltd.	10.00
Marion Laboratories, Inc.	200.00
McNeil Laboratories, Inc.	250.00
Merck, Sharp & Dohme	1,545.00
Mercy Hospital—Janesville	25.00
Milwaukee Gynecological Society	100.00
Mineral Point Chamber of Commerce	10.00
Motor Castings Company	100.00
NMC (Nelson Muffler Corporation) Projects, Inc.	300.00
Northern Engraving Company	100.00
Rock County Medical Assistants Society	10.00
Schering Corporation	100.00
Scott Paper Company Foundation	500.00
Smith, Kline and French Laboratories	250.00
Sola Basic Foundation	200.00
Waukesha Motor Company	100.00
Wisconsin Anti-Tuberculosis Association	500.00
Wisconsin Physicians Service	1,360.00
Wisconsin Psychiatric Clinic, Inc.	500.00
Wisconsin Society of Anesthesiologists, Inc.	100.00
Wisconsin Society of Internal Medicine	500.00
Individuals	5,542.97
	$14,569.97
GRAND TOTAL	$49,013.47

Contributions by

PROJECT

	Amount of Contribution
Donations—General	$30,678.71
Student Loans—General	1,538.00
W. W. Hildebrand, Esquire, Memorial	100.00
Popp Student Loan Fund	2,000.00
Wisconsin Academy of General Practice Loan Fund	40.00
Museum of Medical Progress—General	1,020.00
Museum of Medical Progress—Special Exhibits	800.00
Museum of Medical Progress—T. B. Exhibit	500.00
Other than CESF Projects	10.00
Speakers Service	827.00
Scientific Teaching—General	500.00
J. G. Crownhart Memorial	130.00
Woman's Auxiliary—Projects to be Determined	122.50
Tormey Memorial Fund	125.00
Symposium—The Geriatric Patient	3,100.00
Stonefield—Doctor's Office	202.00
Past Presidents' Plaque	2,500.00
Research Project on Cardiac in Industry	1,550.00
Danforth Memorial Student Loan Fund	2,725.26
Van Dusen Gravestone Restoration	95.00
Kilkenny Memorial Scholarship Fund	100.00
Gill Lamp	350.00
GRAND TOTAL	$49,013.47

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Commended the Foundation for those many programs and projects which have so greatly added to the benefit of the profession and the citizens of Wisconsin.

HOUSE OF DELEGATES ACTION—Accepted the informational report of the Executive Committee of the Board of Trustees of the Charitable, Educational and Scientific Foundation as recommended by the Reference Committee.

■ REPORT OF PRESIDENT—May 1968

Harold J. Kief, MD, Fond du Lac

One year ago I stood at this podium and told you about my thoughts, entitled "Blueprints for Tomorrow." At the same time we promoted the idea of the SMS, meaning progressive leadership in action. I think it has been proven during the year that the SMS has been progressive leadership in action. The committees have been functioning well, new ideas have been promoted, and many of the thoughts that I discussed with you last year are being put into action.

These programs obviously were not made effective by me alone; thus I speak with pride of those who have helped me and your Society in our endeavors —Past President Frank Drew, President-elect Bill James, the other officers and Councilors, and the 480 doctors of your Society who work on our various committees. And I would be very much remiss if I did not thank at this time Mr. Crownhart and all of the associate secretaries and staff who so willingly and kindly helped me and your Society during this past year.

At this time, however, just a few hours before I turn over this medallion symbolizing the reins of the office to President-elect James, I feel I must discuss something with you that is very disturbing to me and to many of our colleagues; this is the daily barrage in the newspapers, magazines and television entitled "Rising Medical Costs—Medicine at the Crossroads."

The pace was set a year ago when President Johnson ordered a national conference on health care costs because he was "shocked" by the rising costs of medical care, especially in 1966 when it rose 6.6 per cent.

Shocking, Mr. President? I don't think so. I have not heard you express shock about the 6+ per cent wage increase voted last week for the Communications Workers of America—a boost that guarantees Bell Telephone workers a minimum of 18 per cent raise in wages over the next three years.

I have heard no pained expressions from the White House about the 6 per cent annual wage settlements recently negotiated in the auto, can and rubber industries.

I have not heard the President's outraged shock at the AP report last month showing that the cost of building a home has gone up "some 10 per cent or more since a year ago."

Yes, Mr. President, I am deeply concerned, as you are—as every citizen is—with the rising cost of living. I am personally doing my best to provide my services to my patients at a reasonable cost. I know that the vast majority of my colleagues are doing the same.

Let's face the facts: Medical care costs more today than yesterday because it costs the doctor and the hospital more to provide it today than yesterday.

A few weeks ago at Marshfield, Wisconsin, Dr. Philip Lee, Assistant Secretary for Health and Scientific Affairs for the Department of Health, Education and Welfare, said: "The biggest barrier to providing comprehensive health care for all Americans is rising costs."

Is it true that health care costs in general, or physicians' fees in particular, stand in the way of health care for most of our people? Let's find out by using the government's own statistics for 1966, the latest I know to be available—a U. S. Department of Commerce report dated July 1967.

Here is how the typical American spends a typical $100 of income on personal consumption items:

Food	$20.00
Housing	14.40
Household operations	14.30
Transportation	12.80
Clothing, accessories and jewelry	10.40
Health care	6.70
Recreation	6.20
Personal business and financial	5.10
Tobacco and liquors	4.80
Other (includes church, welfare, education and travel)	3.50
Personal care	1.80

You will note that health care is but $6.70 out of every $100 spent on personal consumer goods and services each year.

Now consider the fact that the physician receives only about 26 cents of each health care dollar. It is clear, then, that doctor fees are only about $1.77 out of each $100 spent on consumer goods and services each year.

The consumer spends as much on tobacco, liquor, and jewelry as for all health care—twice as much on cars as on health—nearly four times as much for recreation as for doctor bills.

What IS the major barrier, Doctor Lee? Is it the expenditure for doctors—or the expense of liquor—or for cars? What is the proper perspective, Doctor Lee? Or do you prefer to leave this to the "credibility gap?"

In their frequent attacks upon medicine, representatives of the Department of Health, Education and Welfare invariably charge over-use, abuse, unnecessary treatment, and too lengthy hospitalization.

I would say, let's set the record straight, Mr. Cohen. Neither I nor this State Medical Society will support a physician who makes an unconscionable or unreasonable charge for his services. We have had effective medical grievance procedures in this State for many years. They are functioning effectively today. Let those in Wisconsin who feel victimized say so—and I pledge our prompt and thorough action.

More than that, there are review mechanisms in virtually every county medical society—utilization review committees and tissue committees in almost every hospital—all standing guard for the patient. Today more than ever we accept and support peer review of our work and our charges by our own colleagues.

In order to counteract the propaganda that is so blatantly disseminated today from high official sources, I propose that our State Medical Society engage special consultants to research and report the true picture of rising health costs to the public.

"Health costs" is a term that must be defined in its entirety. The public should know that across the nation an average day's stay in the hospital costs $58.06 in 1967—but they should also be told that $36.30 of that was wages and salary. Last year alone there was a hospital payroll increase of 17.4 per cent. This was due primarily to inclusion of hospital employees under federal wage laws, and unionization of employees, together with higher salaries for nurses and paramedical personnel.

I have in my hand a paper listing ten cost-increasing factors inherent in the federal Medicare

rules as contrasted with the State of Wisconsin rules concerning skilled nursing homes. These are just part of the many rules, regulations and edicts of HEW. Let's tell the public, "My God, Mr. Cohen, YOU are raising the cost of health care!"

Furthermore, a mistake that the conservative field of medicine makes is that we forget the kind of an audience to which we are speaking. Forty-six out of every 100 Americans today are under 25 years of age. Another twenty-five out of every 100 are less than 45 years old.

Seventy-one out of every 100 in this country grew up in a world that was different from the one in which the older of us were reared. Their attitudes were shaped by different forces. Their view of the proper place for government in their lives is entirely different.

These seventy-one people do not consider it interference for the G.I. Bill to pay tuition fees for college education after World War II, the Korean war, or now the Vietnam war. They do not consider it interference that the government provides their children with free hot lunches at school, or that the government will guarantee a loan for their house enabling them to buy a nice home with a small down payment or none at all.

I don't think they are likely to consider it interference if the government sets standards for product packaging in an effort to protect the poor housewife. It is clear that our approach to the problem of telling our story must be different. I don't think we can win over the public by knocking Santa Claus. Therefore, I think this Society needs the services of specialized personnel to develop and disseminate our story.

I further suggest that on the national level the costs of health care as an entity are not understood. A few weeks ago a delegation of Wisconsin physicians visited our congressmen in Washington. Several of them asked, "What are you going to do about the rising cost of health care?" They, the congressmen, have had information from only one source, obviously not the AMA.

I therefore suggest that our delegates to our national Association go to San Francisco next month and demand the AMA develop a national program to define and explain the costs of health care, and nationally to promote the M.D. image in its proper perspective as to health care expenditures.

Furthermore, as some of you know, we are installing some new and sophisticated telephone equipment at our Madison headquarters. I understand there is a recording gadget available today which permits someone—such as an editor or TV manager in Fond du Lac or Wausau—to call our office without charge and get a last-minute tape-recorded message on some medical topic. The device permits the caller to ask questions and within a short time have a recorded answer from a qualified spokesman.

We DO have the spokesmen. Let's use the marvels of electronics to help us communicate with the people of our State. The cost to the Society would be nominal. The service would be unique to the press of Wisconsin, and we might help to break the credibility gap in medical care.

Finally, I believe we can provide new leadership in health expenditures control. We could do so with an educational program to assist physicians and those who work together in hospitals and other special-care situations available to us today. I suggest this leadership be exercised through a Comprehensive Health Expenditures Commission (with the initials C-H-E-C—CHEC). It would include physicians, hospital trustees, and administrators, nurses, pharmacists, dentists, and representatives of nursing homes and home care programs.

I feel that the physician can exercise a good influence on expenditures by or on behalf of the patient, but only when the related parties to that care aid and assist in the process. The educational opportunity for CHEC is almost unlimited, and the potential for economic relief to the patient is great.

Gentlemen of the House, these are my suggestions as I leave the office which you entrusted to me a year ago. Let us seek to achieve a new perspective of the role of the physician in the totality of health care—a perspective that is both understandable and acceptable to the American public.

Our profession is engaged in a never-ending struggle to provide health care of excellent quality and at reasonable cost. This is as it should be. To this end, I dedicate myself—and I trust that our Society will continue to do the same.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of the President's report with the following suggestions:

(1) That the President's recommendation concerning the engagement of special consultants to research and report the true picture of health costs to the public be referred to the Council for its consideration and implementation within the resources of the Society, as well as those which might be made available to it.

(2) That the Society reaffirm its position as stated in Resolution No. 30 which was introduced by the Wisconsin delegation at the 1967 clinical meeting of the AMA calling for the proper identification of the many components of health care costs, and that the delegates to the AMA prepare and introduce a resolution at the San Francisco meeting this June which would embody the President's recommendation concerning health care costs.

(3) That the Council further explore the President's recommendation relating to new and sophisticated telephone equipment.

(4) That the recommendation for creation of a Comprehensive Health Expenditure Commission (C-H-E-C) be referred to the Council for further study and possible correlation with that portion of the supplementary report of the Council relating to health care costs and manpower, and that consideration be given to incorporating some of this within the framework of the Wisconsin Work Week of Health.

HOUSE OF DELEGATES ACTION—Accepted the report of the President as recommended by the Reference Committee.

REPORT OF PRESIDENT-ELECT—May 1968

William D. James, MD, Oconomowoc

The report of the President-elect was printed in the June 1968 issue of the *Wisconsin Medical Journal*, beginning at page 287.

The President-elect appointed the following standing committee members where terms expired or vacancies occurred:

COMMITTEE ON CANCER

G. A. Smiley, MD, Delavan
R. C. Frank, MD, Eau Claire
G. I. Uhrich, MD, La Crosse
J. F. Brown, MD, Rhinelander
Helen Gurkow, MD, Platteville
J. J. Gramling, MD, Milwaukee (reappointed)
G. A. Smiley, MD, Delavan (reappointed chairman)

COMMITTEE ON GRIEVANCES

E. W. Mason, MD, Milwaukee
E. D. Sorenson, MD, Elkhorn
R. W. Mason, MD, Marshfield (reappointed)
E. W. Mason, MD, Milwaukee (reappointed chairman)

NEW PRESIDENT—Dr. William D. James, left, of Oconomowoc took the oath of office administered by Dr. James C. Fox of La Crosse, retiring chairman of the Council.

COMMISSION ON PUBLIC POLICY

C. F. Broderick, MD, Wisconsin Dells
R. L. Gilbert, MD, La Crosse (reappointed)
J. C. Fralich, MD, Racine
R. C. Wixson, MD, Madison
J. G. Frisch, MD, Milwaukee
Wayne Boulanger, MD, Milwaukee (appointed)
W. T. Russell, MD, Sun Prairie (reappointed chairman)

COMMISSION ON SCIENTIFIC MEDICINE

N. O. Becker, MD, Fond du Lac
S. E. Sivertson, MD, Madison (appointed)

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION

L. W. Schrank, MD, Waupun
R. S. Galgano, MD, Delavan (reappointed)
Philip G. Piper, MD, Madison (appointed)
George B. Murphy, Jr., MD, La Crosse (reappointed chairman)

COMMISSION ON HEALTH INFORMATION

R. G. Hansel, MD, Baraboo (reappointed)
J. M. Wilke, MD, Madison
W. C. Harris, MD, Racine (appointed)
J. C. Devitt, MD, Milwaukee (reappointed chairman)

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—The reference committee was impressed by the challenge posed by the President-elect. In essence his message was such that physicians can only be involved and on an increasing basis for the ultimate benefit of the entire citizenry. It recommended acceptance of the President-elect's report.

HOUSE OF DELEGATES ACTION—Accepted the report of the President-elect, and approved committee appointments.

REPORT OF SECRETARY—May 1968

Mr. C. H. Crownhart, Madison

I report to you this evening not in my dual capacity but on behalf of two interests. One is that of my function of being your Secretary and General Manager. Unlike some reports that you may have heard over radio or television on some other types of activities, I would like to say to you that the state of the union in the State Medical Society is in pretty good shape.

You are solid citizens first; you are dedicated physicians, and you are serving public health and the welfare of our people. The awesome moment of death, resignation or campaign oratory can never disturb that type of solidarity that you have developed, and the state of the union in the Medical Society is good.

On behalf of the Commission on Medical Care Plans, and at its request, about a month ago, in a rather informal fashion, I would like to tell you of some of its planning—not that it is going to reach a conclusion without your consent, but it is studying and it is working, because the economics of medicine can no more be static than the science of medicine; and we do have some new areas.

In the area of insurance itself, the family known to us as Wisconsin Physicians Service, Blue Shield of Wisconsin, there are at the moment studies under way through Mr. Tiffany, our actuary, and others of the staff, to determine if there can be a method (one suggested here in Milwaukee County a quarter-century ago) of the postpayment of medical bills that are not included within the insurance policy itself, and that the device would be that of which you have one in your pocket, if not a dozen—a credit card, in which the Wisconsin Physicians Service would assure reasonable and customary charges on behalf of the people who want the benefit of this mechanism, and will assure you reasonable and prompt payment, and will undertake to be the intermediary as to some elements of society. This is a study. It is not any profound conclusion.

Another is the possible extension of the insurance benefit into that field which occupies so much of your attention and that of the men of the Legislature—accidents—motor boats, motor vehicles, no matter what the cause—and that it may be possible within the purvue of the insurance program to provide some added benefits perhaps in the character of disability, which should not increase the premium excessively.

These and other activities are now under way, not in fear of the government nor because of it, but because of your responsibility to the people.

A short time ago we had a rather distinguished visitor come to Wisconsin. I didn't see him, but he is the king of a friendly country. As kings are wont to do, when he first arrived in my birthplace of Superior, Wisconsin, where I share no racial background with him but where there are a great many who do, the king traveled and came to Madison. He hadn't been here for some decades. The King of Norway could not be housed in the gubernatorial mansion because in the great State of Wisconsin the security that should be offered to such an individual could not be promised in that area. This was reported to me on good authority, and I would not pass it on to you without it.

Also in Madison, in the walls of Bascom Hill, erected in 1910, is the motto or slogan: "Whatever may be the limitations which trammel learning elsewhere, we believe that the great State University

of Wisconsin should ever encourage that continued and fearless shifting and winnowing by which alone truth can be found."

So, the Commission comes to you, as it will to the Council, and in the Scandinavian concept of the ombudsman, the tribunal in protection of the public interest against assault upon that interest by government, which can become autocratic and dictatorial, it proposes that under the direction of the State Medical Society, and quite possibly through the Foundation, the ombudsman be brought into the picture to evaluate this multitude of health proposals that spring like the gurgling waters of Florida, perhaps impregnated with sulfur or having a lot of shining fish, and perhaps very worthwhile. But proponents tend, as I do, to think in terms of what they favor and not in terms of what may be against it.

Whatever huge government expenses come about in this State—and I suspect they will—they should not be directed to the economic interest of an area unless that area represents a public health need to which you can dedicate your stature, your strength, your education and your future.

One of our governmental groups within the past several days, having some thirty-eight citizens upon it of whom but a few are physicians, were asked to list some dozen or more projects which each one of them felt had priority in the scheme of public health affairs of the State. I say this somewhat facetiously, but if you put forty men together and ask them to list a dozen or fifteen things they think ought to be done, you will have quite an index coming up, and a computer might come in handy.

We appeared before Mr. Slichter last fall, Doctor Kief, Doctor Drew, Doctor James and myself, to urge upon the Governor's Task Force that in the order of things the needs of the University of Wisconsin Medical School be classified as imperative and urgent, and that no matter what our opinion might have been in the past (or mine in particular), the physical location of the school certainly needed re-evaluation.

We appeared before Mr. Slichter on that same occasion and urged that the second priority—indeed an equal priority—be given to Marquette School of Medicine, and that third in line for consideration be the location and staffing and physical plant of a third school of medicine in this State.

This is in response in part to these many inquiries that come, and to the inquiries that Dr. Kief presents of these many projects for commitments of $300,000 or $500,000 to build something new here, to get a new gadget there; that we in Wisconsin, whatever may be the limitations elsewhere, should ever encourage that continued, fearless sifting and winnowing by which alone truth can be found.

RECOMMENDATION OF REFERENCE COMMITTEE ON FINANCES—Noted its concern equally with Mr. Crownhart as to the importance of the Governor's Task Force on Medical Education, and urged detailed review of the report of the Commission on Hospital Relations and Medical Education.

HOUSE OF DELEGATES ACTION—Accepted the Secretary's Report as recommended by the Reference Committee.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON FINANCES—Recommended special commendation to the Secretary and to the Council for their leadership and supervision of all Society activities and finances.

HOUSE OF DELEGATES ACTION—Accepted the recommendation of the Reference Committee.

■ REPORT OF TREASURER—Year Ended December 31, 1967

F. L. Weston, MD, Madison

In accordance with Section 3, Chapter 5 of the Bylaws of our Society, I submit to you my annual report.

As in previous years, I am reporting to you only on those funds which are the direct responsibility of the Treasurer, designated as the Society's General Fund. Information on the financial condition and income and expenditures of related activities of the Society is submitted to you separately, in accordance with a recommendation made to you in October, 1963 by the Reference Committee on Reports of Officers, which you adopted.

The following Exhibits and Schedules make up this report:

Exhibit A	Balance Sheet at December 31, 1967
Schedule A-1	Reconciliation of Net Worth at December 31, 1967
Exhibit B	Statement of Income and Expense—General Fund—Year Ended December 31, 1967

[The exhibits and schedule, noted above, also appear at pp. 486–487 in the Consolidated Balance Sheet, which follows, and are not printed here.]

The records of the State Medical Society of Wisconsin have been audited for the year 1967 by Donald E. Gill & Company, Certified Public Accountants. A representative of this firm is present and available for consultation during the course of this Annual Meeting.

RECOMMENDATION OF REFERENCE COMMITTEE ON FINANCES—Commended the treasurer, Dr. Frank L. Weston, for the many hours he has devoted over the years in directing the financial affairs of the Society.

HOUSE OF DELEGATES ACTION—Accepted the Treasurer's Report as recommended by the Reference Committee.

■ CONSOLIDATED BALANCE SHEET—December 31, 1967

State Medical Society of Wisconsin and Related Organizations, Madison, Wisconsin

To Council of the State
Medical Society of Wisconsin

We have audited the accounts of the State Medical Society of Wisconsin, a Wisconsin Corporation, and accounts of its related organizations, Madison, Wisconsin, for the year ended December 31, 1967. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances, except that it was not practicable to confirm receivables from government departments, as to which we have satisfied ourselves by means of other auditing procedures.

In our opinion the accompanying Balance Sheet and notes which are a part of it presents fairly the financial condition of the State Medical Society of Wisconsin and related organizations at December 31, 1967 in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

/s/ Donald E. Gill & Company
Certified Public Accountants
Madison, Wisconsin

April 22, 1968

STATE MEDICAL SOCIETY OF WISCONSIN AND RELATED ORGANIZATIONS
Madison, Wisconsin

CONSOLIDATED BALANCE SHEET
December 31, 1967

ASSETS		
Cash	$ 423,483.04	
Current Receivables	2,253,281.56	
Invested Funds, Accrued Interest and Dividends Receivable (Note 1)	11,879,332.99	
Student Loans Receivable and Accrued Interest	158,427.00	
Land, Buildings, Equipment and Vehicles—Net Book Value (Note 2)	1,744,979.69	
Organization Expense	804.35	
Prepaid Expenses and Deferred Charges	115,723.88	
Deposits	1,251.10	
Long Term Receivables	20,000.00	
TOTAL ASSETS		$16,597,283.61
LIABILITIES, RESERVES AND CAPITAL		
Current Payables, Other Than Benefits	$ 344,406.81	
Mortgages and Debentures Payable	37,500.00	
Deposits Held	45,089.23	
Old Outstanding Checks	12,413.58	
Benefits Payable	6,321,512.43	
Unearned Income	3,011,803.17	
Reserves of Medical Care Plans	5,649,514.69	
TOTAL LIABILITIES AND RESERVES	$15,422,239.91	
Net Worth of General Fund	109,169.68	
Capital of SMS Realty Corporation	309,302.94	
Restricted Principal of Funds	756,571.08	
TOTAL LIABILITIES, RESERVES AND CAPITAL		$16,597,283.61
CONTINGENT LIABILITIES		
Contractual Future Adjustment of Income Under Federal Employee Program		See NOTE 3

Notes one to five inclusive which follow are an integral part of this Balance Sheet.

NOTES

1. Invested funds shown above are included in some cases at book value and in others at market value. In the case of the Pension Plan values on the books are adjusted annually to market values in accordance with provisions of the Trust Agreement. In the case of Wisconsin Physicians Service, stocks are valued at those market values prescribed by the National Association of Insurance Commissioners, which were, in total, more than book value by $178,193.91. For all other securities of Wisconsin Physicians Service, the amortized cost is used. The securities owned by the Charitable, Educational and Scientific Foundation are shown at book value, which was less than market value on December 31, 1967 by $31,144.27.

2. Fixed assets shown above at book value include those of the Charitable, Educational and Scientific Foundation, some of which are shown at appraisal values.

3. Wisconsin Physicians Service participates in a national program covering Federal employees. Final operating results of the entire program for each contract period are reflected in pro rata allocations to each plan. Information relating to the years 1966 and 1967 have not yet become final. Adverse results in total operations of the program could occasion an additional liability when this information is known.

4. Certain payables and receivables between the State Medical Society of Wisconsin and its related organizations are eliminated from assets and liabilities above. These are:

Current Accounts	$ 59,072.87
Mortgage Loans	541,729.12
Leasehold Improvements (Shown as Reduction of Fixed Assets of SMS Realty Corporation)	92,156.25
Total	$692,958.24

5. The term, "Restricted Principal of Funds", in this Balance Sheet refers to the Net Worth of those organizations whose funds may be used solely for specifically designated purposes. There is no equity of the State Medical Society of Wisconsin in any of these funds. They are:

Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin

Student Loan Fund of the State Medical Society of Wisconsin

Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin

RECONCILIATION OF NET WORTH
Year Ended December 31, 1967

	State Medical Society of Wisconsin	SMS Realty Corporation	Restricted Funds	Total
Balance—January 1, 1967	$103,294.22	$283,568.14	$625,996.31	$1,012,858.67
Increases	5,875.46	25,734.80	144,962.88	176,573.14
Total	$109,169.68	$309,302.94	$770,959.19	$1,189,431.81
Decreases			14,388.11	14,388.11
Balance—December 31, 1967	$109,169.68	$309,302.94	$756,571.08	$1,175,043.70

The balance sheets and statements of income and expense for separate divisions and related organizations appear in the following order:

State Medical Society of Wisconsin (General Fund)

Wisconsin Medical Journal

Wisconsin Physicians Service

Civilian Health and Medical Program of the Uniformed Services

Supplemental Medical Insurance Benefits for the Aged

Wisconsin Medical Assistance Program

SMS Realty Corporation

Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin

Student Loan Fund of the State Medical Society of Wisconsin

Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wis. 53701; or tel. (608) 257–6781.

Exhibit A

STATE MEDICAL SOCIETY OF WISCONSIN

General Fund
Madison, Wisconsin

BALANCE SHEET
December 31, 1967

ASSETS		
Current Assets		
Cash	$108,238.23	
Accounts Receivable—General	980.71	
Due from Employees	366.14	
Due from Charitable, Educational and Scientific Foundation, Incorporated	20,778.22	
Due from SMS Realty Corporation	10,805.36	
Due from Wisconsin Medical Journal	4,688.03	
Due from Wisconsin Physicians Service	45,862.18	
Investments	8,412.50	
Guaranty Deposit	425.00	
Unexpired Insurance	436.10	
Total		$200,992.47
Long-Term Assets		
Loan Receivable		20,000.00
Capital Invested in Divisions		
Wisconsin Medical Journal		19,471.85
Fixed Assets		
Furniture and Equipment	$ 37,405.41	
Less: Accumulated Depreciation	31,926.44	
Total		5,478.97
Prepaid Expenses and Deferred Charges		
Prepaid Postage and Deposits	$ 4,841.54	
Inventory of Forms and Office Supplies	8,414.85	
Other Deferred Expense	3,941.82	
Total		17,198.21
TOTAL ASSETS		$263,141.50
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable	$ 43,901.30	
Due Employees	1,099.98	
Due Employees' Pension Plan	162.30	
Dues—Suspense	135.00	
Dues Held for Section on Ophthalmology	7,600.00	
Accrued Payroll Taxes	23,695.57	
Accrued Property Taxes	5,498.68	
Accrued Employees' Insurance	2,581.49	
Total		$ 84,674.32
Deferred Income		
Prepaid Membership Dues	$ 55,704.00	
Other Prepaid Income	13,593.50	
Total		69,297.50
TOTAL LIABILITIES		$153,971.82
NET WORTH		
Capital of General Fund—January 1, 1967	$103,294.22	
Additions		
Increase in Capital Invested in Wisconsin Medical Journal	$1,295.65	
Excess—Income over Expense—1967	4,579.81	
Total Additions	5,875.46	
Total Capital—December 31, 1967		109,169.68
TOTAL LIABILITIES AND CAPITAL		$263,141.50

NOTE: Reserves of Wisconsin Physicians Service, A Division of the State Medical Society of Wisconsin, are not included in this statement.

Exhibit B

STATE MEDICAL SOCIETY OF WISCONSIN

General Fund
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1967

INCOME		
Members' 1967 Dues		$436,672.00
Members' Dues—Prior Years		762.37
Dues—Section on Medical History		1,315.00
Annual Meeting		33,518.95
Administrative Services		5,157.43
Miscellaneous Income		1,305.83
Income on Funds Invested		4,230.12
Gain on Disposal of Fixed Assets		363.04
TOTAL INCOME		$483,324.74
EXPENSE		
Payroll	$190,603.95	
Insurance—Employees	5,279.63	
Retirement Plan Contributions	9,650.08	
Payroll Taxes	6,054.07	
Conference Expense	37,962.07	
Association Dues	1,991.32	
Travel Expense—Staff	15,672.73	
Telephone	4,717.76	
Resource Material	1,263.27	
Printing and Forms	33,040.08	
Postage	14,042.11	
Office Supplies	4,443.70	
Promotion	14,958.63	
Insurance—General	2,796.67	
Grants and Appropriations	30,835.00	
Cafeteria Expense	2,103.55	
Speakers Expense	8,895.16	
Outside Services	21,211.84	
Miscellaneous Expense	3,494.49	
Auditing and Accounting Consultation	4,813.50	
Legal Counsel	14,382.57	
Legislative Retainer	13,400.00	
Depreciation	2,168.38	
Rent—Central Office	37,815.00	
Rent—Other	6,594.96	
Rental of Equipment	1,452.02	
Equipment Repair and Maintenance	984.99	
Personal Property Tax	631.25	
Total	$491,258.78	
Less: Portion of Above Expenses Recovered by Services Furnished to Others	23,788.85	
TOTAL EXPENSES		467,469.93
Excess—Income over Expense Before Special Item		$ 15,854.81
SPECIAL ITEM		
Reallocation of Prior Year Costs		11,275.00
Excess—Income over Expense		$ 4,579.81

NOTES

(1) The above excess of income over expense for 1967 is closed to Net Worth accounts as follows:

To Capital Surplus	$ 1,056.78
To Reserve for Budget Carryover	1,500.00
To Unappropriated Surplus	813.55
Total—General	$ 3,370.33
To Section on Medical History	1,209.48
Total	$ 4,579.81

(2) As a result of a review of costs allocated to related interests, an adjustment of allocations made in 1965 and 1966 was made. This adjustment is shown above as a Special Item.

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Schedule A-1

STATE MEDICAL SOCIETY OF WISCONSIN

General Fund
Madison, Wisconsin

ANALYSIS OF CAPITAL
Year Ended December 31, 1967

	Capital Surplus	Medical History	Wisconsin Medical Journal	Budget Carry-Overs	Unappropriated Surplus	Total
Balance—January 1, 1967	$4,422.19	$2,910.78	$18,176.20	$13,904.46	$63,880.59	$103,294.22
Additions						
Increase in Capital of Wisconsin Medical Journal	$	$	$ 1,295.65	$	$	$ 1,295.65
Excess of Medical History Dues over Expenses		1,209.48				1,209.48
Transfers	1,056.78			(12,642.46)	11,585.68	
Excess of General Income over Expenses					3,370.33	3,370.33
Transfer of 1968 Budget Carry-Over				1,500.00	(1,500.00)	
Total Additions	$1,056.78	$1,209.48	$ 1,295.65	($11,142.46)	$13,456.01	$ 5,875.46
Deductions						
None	$	$	$	$	$	$
Balance—December 31, 1967	$5,478.97	$4,120.26	$19,471.85	$ 2,762.00	$77,336.60	$109,169.68
Detail of Budget Carry-Overs						
Open Panels				$ 1,262.00		
Town and Gown Symposium				1,500.00		
Total				$ 2,762.00		

Exhibit A

WISCONSIN MEDICAL JOURNAL

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET
December 31, 1967

ASSETS		
Current Assets		
Cash		$15,079.46
Accounts Receivable—Advertisers		9,867.81
Accounts Receivable—Other		611.57
Copyright Deposits		30.00
Postage Deposits		296.10
Prepaid Insurance		136.54
Total		$26,021.48
Fixed Assets		
Furniture and Equipment	$ 1,487.46	
Less: Accumulated Depreciation	1,008.67	
Total		478.79
Prepaid Expenses and Deferred Charges		
Mailing Envelope Charges	$ 224.03	
Deferred Blue Book Expense	1,168.00	
Prepaid Cuts Expense	9.85	
Total		1,401.88
TOTAL ASSETS		$27,902.15
LIABILITIES AND CAPITAL		
Accounts Payable	$ 3,742.27	
Due State Medical Society	4,688.03	
Total Liabilities		$ 8,430.30
Capital—January 1, 1967	$18,176.20	
Add: Excess of Income Over Expense—1967	1,295.65	
Capital—December 31, 1967		19,471.85
TOTAL LIABILITIES AND CAPITAL		$27,902.15

NOTE: The capital of the Wisconsin Medical Journal is carried as a working capital advance among the assets of the State Medical Society of Wisconsin General Fund.

Exhibit B

WISCONSIN MEDICAL JOURNAL

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1967

INCOME			
Advertising Income			$52,256.50
Subscription and Supplemental Income			1,571.12
Reprint Income			2,135.47
Recovery of Charged Off Account			194.53
TOTAL INCOME			$56,157.62
EXPENSES			
Direct Payroll		$11,529.09	
Printing	$41,565.62		
Less: Costs Recoverable	10,776.25	30,789.37	
Cuts		1,298.63	
Postage		2,058.24	
Rent		3,187.00	
Reprints		1,788.83	
Editorial Expense		156.70	
Advertising Discounts		9.32	
Copyright Expense		72.00	
Telephone and Telegraph		19.10	
Office Supplies and Expense		425.43	
Accounting Service		257.45	
Depreciation		115.32	
Insurance—Employees		554.92	
Insurance—General		114.37	
Legal Services		729.50	
Miscellaneous Expense		342.83	
Outside Services		45.20	
Printing and Forms		372.20	
Social Security Tax		463.94	
Federal Unemployment Tax		24.31	
Wisconsin Unemployment Tax		58.22	
Retirement Plan Contributions		450.00	
TOTAL EXPENSES			54,861.97
EXCESS OF INCOME OVER EXPENSE			$ 1,295.65

Exhibit A

WISCONSIN PHYSICIANS SERVICE

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET
December 31, 1967

ASSETS

Current Assets		
Cash in Office	$ 23,336.43	
Cash in Banks	67,615.32	
Due from Agents	345.07	
Due from Plan Administrator, Federal Employee Program	37,937.87	
Due from Civilian Health and Medical Program of the Uniformed Services—Current	27,240.56	
Due from Supplementary Medical Insurance Benefits for the Aged	79,359.16	
Due from Wisconsin Medical Assistance Program	132,305.00	
Premiums Receivable	1,271,456.60	
Refunds Receivable	41,928.00	
Other Current Receivables	11,829.96	
Unexpired Insurance	2,547.81	
Total		$ 1,695,901.78
Securities (Note 1)	$10,837,881.19	
Bank Deposits at Interest	266,553.13	
Accrued Interest Receivable	120,473.02	
Total		11,224,907.34
Total Current Assets		$12,920,809.12
Advances and Other Receivables		
Advances to Civilian Health and Medical Program of the Uniformed Services	$ 80,000.00	
Mortgage Loans Receivable	541,729.12	
Total Advances and Mortgage Loans		621,729.12
Fixed Assets		
Real Estate	$ 606,267.06	
Leasehold Improvements Unamortized	100,561.74	
Office Equipment	416,117.12	
Automobiles	10,551.27	
Total	$ 1,133,497.19	
Less: Accumulated Depreciation	214,001.73	
Total Fixed Assets		919,495.46
Deferred Charges		
Supplies and Forms Inventories	$ 73,553.83	
Other Deferred Expense	12,016.08	
Total Deferred Charges		85,569.91
TOTAL ASSETS		$14,547,603.61

LIABILITIES AND RESERVES

Current Liabilities		
Accounts Payable	$ 114,079.31	
Due State Medical Society of Wisconsin	45,862.18	
Due SMS Realty Corporation	27,148.58	
Due Plan Administrator, Federal Employee Program	11,000.00	
Accrued Expenses	17,194.54	
Old Outstanding Checks	12,413.58	
Premium and Claim Deposits	45,089.23	
Subscriber Benefits Payable, Including Cases in Process or Unreported	5,632,765.10	
Provision for Merit Rating Credits	52,100.78	
Total Current Liabilities		$ 5,957,653.30
Deferred Income		
Premiums Not Earned		2,940,435.62
TOTAL LIABILITIES		$ 8,898,088.92
Reserves		
Reserves—January 1, 1967	$ 4,355,690.37	
Add: Excess—Income Over Expenses—Year 1967	1,114,151.95	
Transfer to Reserve for Market Values of Securities	179,672.37	
Reserves—December 31, 1967		5,649,514.69
TOTAL LIABILITIES AND RESERVES		$14,547,603.61
Contingent Liabilities		
Federal Employee Program Income		Note 2

NOTES—

1. Stocks are shown at market value, and Bonds and Notes are shown at amortized book value on December 31, 1967.

Stocks were valued at market value by use of valuation data prescribed by the State of Wisconsin Insurance Department. A comparison of valuation of stocks is given below:

Stocks at Book Value	$2,202,290.09
Stocks at Market Value—Insurance Method	$2,380,484.00
Stocks at Market Value—Current Financial Publications	$2,366,678.25

2. Wisconsin Physicians Service participates in a national program covering Federal employees. Final operating results of the entire program for each contract period are reflected in pro rata allocations to each plan. Information relating to the period January 1, 1967 to December 31, 1967 has not yet become final. Adverse results in total operations of the program could occasion an additional liability when this information is known.

Exhibit B

WISCONSIN PHYSICIANS SERVICE

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1967

INCOME

Earned Premium Income, Net of Agents' Commissions		$22,866,175.90
Benefits Incurred		19,670,302.48
Net Underwriting Gain Less Agents' Commissions		$ 3,195,873.42

EXPENSES

Joint Plan Expense—Federal Employee Program	$ 360.20		
Payroll	1,338,756.29		
Payroll Taxes	67,170.70		
Retirement Plan Contributions and Employees' Insurance	41,316.44		
Conference Expense	32,983.49		
Association Dues	13,593.50		
Travel and Auto Rental Expense—Staff	123,786.73		
Telephone and Teletype Service	35,359.12		
Resource Material	3,193.81		
Printing and Forms	76,832.98		
Postage	64,162.88		
Office Supplies	18,728.99		
Promotion	181,264.99		
General Insurance	9,787.48		
Cafeteria Expense	7,446.55		
Miscellaneous Expense	29,723.19		
Auditing and Accounting Consultation Services	12,276.88		
Actuarial Services	8,275.63		
Legal Counsel	27,935.82		
Outside Underwriting Services	9,071.49		
Medical Consultant	4,343.75		
Field Service Expense	12,505.64		
Amortization of Leasehold Improvements	4,898.14		
Depreciation	27,102.86		
Rent—Central Office	180,554.35		
Rent—Other Offices	7,824.40		
Rental of Data Processing and Copying Equipment	128,203.99		
Maintenance and Repair of Equipment	5,699.18		
Property Taxes	8,908.08		
Temporary Help	17,379.44		
Insurance Department Examination	2,571.19		
Total	$2,502,018.18		
Less: Portions of Above Expenses Recovered by Services Rendered to Others	24,324.02		
Net Administrative Expense			$ 2,477,694.16
Net Gain From Operations			$ 718,179.26
Less: Excess of Expenses of Medical Assistance Program over Contract Payments			77,818.60
Total			$ 640,360.66
Investment and Other Income			
Interest Earned	$373,119.20		
Dividend Income	69,306.28		
Amortization of Premiums and Discounts	13,492.46		
Rental Income	9,612.50		
Gain on Sales of Securities	29,120.65		
Total		$ 494,651.09	

(Continued on next page)

(Continued)

Less: Investment Expenses			
Consultation, Safekeeping and Other Investment Expense	$ 8,921.98		
Expense of Rental Properties	12,587.58		
Total		21,509.56	
Net Investment Income		$ 473,141.53	
Other Income	$ 439.71		
Gain on Sales of Fixed Assets	210.05		
Total Other Income		649.76	
Total Investment and Other Income			$ 473,791.29
Excess—Income Over Expense			$ 1,114,151.95

Exhibit A

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

A Division of the State Medical Society of Wisconsin Madison, Wisconsin

BALANCE SHEET December 31, 1967

ASSETS		
Current Assets		
Cash in First National Bank, Madison, Wisconsin	$ 57,917.25	
Cash in Dakota National Bank, Bismarck, North Dakota	12,910.68	
Due From U. S. Government, Office for the Civilian Health and Medical Program of the Uniformed Services	35,153.76	
Due From State Societies—Sub Contracts	1,510.53	
Suspended Claims	82.50	
Refunds Receivable	518.20	
TOTAL ASSETS		$108,092.92
LIABILITIES		
Current Liabilities		
Due Wisconsin Physicians Service—Current	$ 27,240.56	
Due North Dakota State Medical Association	744.36	
Claims Due Physicians, Wisconsin	108.00	
Total Current Liabilities	$ 28,092.92	
Advances		
Advanced Funds—Wisconsin Physicians Service	80,000.00	
TOTAL LIABILITIES		$108,092.92

Exhibit B

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

A Division of the State Medical Society of Wisconsin Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE Year Ended December 31, 1967

INCOME		
U. S. Government Office for the Civilian Health and Medical Program of the Uniformed Services		$ 34,729.45
Indiana State Medical Association		3,496.54
Iowa State Medical Society		1,663.95
Minnesota State Medical Association		1,920.95
South Dakota State Medical Association		786.62
TOTAL INCOME		$ 42,597.51
EXPENSES		
Auditing and Consultation Services	$ 705.89	
Office Supplies and Expense	1,900.82	
Payroll	19,319.38	
Postage and Expense	1,899.80	
Printing and Forms	990.17	
Rent	180.00	
Telephone Services	477.43	
Machine Service Expense	8,600.88	
Overhead Expense	6,941.67	
Legal Services	530.50	
Medical Consulting Service Charge	259.39	
Travel Expense	588.46	
Resource Material	18.00	
Miscellaneous Expense	185.12	
TOTAL EXPENSES		42,597.51
Balance		$ None

Exhibit A

SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED

A Division of the State Medical Society of Wisconsin Madison, Wisconsin

BALANCE SHEET December 31, 1967

ASSETS		
Current Assets		
Cash on Hand	$ 11,719.21	
Cash in Bank	34,655.54	
Due From U. S. Government, Social Security Administration	147,548.98	
Refunds Receivable	12.80	
Prepaid Insurance	899.24	
TOTAL ASSETS		$194,835.77
LIABILITIES		
Current Liabilities		
Benefits Due Providers of Service	$115,476.61	
Due Wisconsin Physicians Service	79,359.16	
TOTAL LIABILITIES		$194,835.77

Exhibit B

SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED

A Division of the State Medical Society of Wisconsin Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSES January 1, 1967 to December 31, 1967

INCOME		
U. S. Government, Social Security Administration		$1,352,796.93
EXPENSES		
Payroll	$671,432.62	
Overhead	149,992.82	
Conference Expenses	2,180.89	
Association Dues	5,159.49	
Travel Expense	6,349.61	
Provider Relations—Publications	332.40	
Telephone and Telegraph	8,511.92	
Resource Material	200.40	
Printing and Forms	54,140.87	
Postage and Freight	56,419.44	
Office Supplies	25,451.96	
General Insurance	1,089.83	
Cafeteria Expense	3,140.63	
Outside Services	31,975.46	
Accounting Services	1,733.48	
Legal Counsel	1,251.91	
Medical Consultant	2,900.02	
Temporary Help	14,813.76	
IBM Machine Time	292,112.92	
Rent—Other Equipment	4,603.21	
Maintenance and Repairs—Equipment	152.58	
Miscellaneous Expense	18,850.71	
TOTAL		1,352,796.93
Balance		$ None

Exhibit A

WISCONSIN MEDICAL ASSISTANCE PROGRAM

A Division of the State Medical Society of Wisconsin Madison, Wisconsin

BALANCE SHEET December 31, 1967

ASSETS		
Current Assets		
Cash in Bank	$ 40,217.78	
Due From State of Wisconsin State Department of Public Welfare	690,092.46	
Prepaid Insurance	549.23	
TOTAL ASSETS		$730,859.47
LIABILITIES		
Current Liabilities		
Due Wisconsin Physicians Service	$132,305.00	
Benefits Due Providers	573,162.72	
Suspense Account	25,391.75	
TOTAL LIABILITIES		$730,859.47

Exhibit B

WISCONSIN MEDICAL ASSISTANCE PROGRAM

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
January 1, 1967 to December 31, 1967

INCOME		
State of Wisconsin, State Department of Public Welfare		$696,993.98
Wisconsin Physicians Service, Administrative Costs Absorbed		77,818.60
TOTAL INCOME		$774,812.58
EXPENSES		
Payroll	$404,726.05	
Overhead	87,010.63	
Conference Expenses	266.68	
Telephone and Telegraph	7,334.72	
Resource Material	188.75	
Printing and Forms	45,966.97	
Postage and Freight	16,154.62	
Office Supplies	9,976.23	
General Insurance	730.65	
Cafeteria Expense	2,265.07	
Accounting Services	1,130.02	
Legal Counsel	2,923.91	
Temporary Help	17,848.18	
IBM Machine Time	109,361.99	
Rent—Other Equipment	4,722.53	
Outside Services	49,322.47	
Travel Expense	3,205.51	
Miscellaneous	11,677.60	
TOTAL EXPENSES		774,812.58
Balance		$ None

Exhibit A

SMS REALTY CORPORATION

Madison, Wisconsin

BALANCE SHEET
December 31, 1967

ASSETS		
Current Assets		
Cash		$ 9,288.54
Accounts Receivable		893.40
Due from Charitable, Educational and Scientific Foundation		178.41
Due from Wisconsin Physicians Service		27,148.58
Investments		181,535.78
Inventories		2,321.91
Accrued Interest Receivable		971.81
Deposits (See Note)		500.00
Unexpired Insurance		436.39
Total Current Assets		$223,274.82
Fixed Assets		
Real Estate—Office Building	$ 883,719.86	
Real Estate—Storage Building	101,200.94	
Other Real Estate	17,659.49	
Automobiles and Equipment	85,229.91	
Total	$1,087,810.20	
Less: Accumulated Depreciation	316,923.67	
Net Book Value	$ 770,886.53	
Less: Leasehold Improvements Paid by Wisconsin Physicians Service	92,156.25	
Total Fixed Assets		678,730.28
Intangible Assets		
Organization Expense		644.35
Deferred Charges		
Prepaid Licenses	$ 84.30	
Other Deferred Charges	1,651.14	
Total Deferred Charges		1,735.44
TOTAL ASSETS		$904,384.89
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable—Trade		$ 7,245.20
Accrued Sales Tax		359.89
Accrued Property Taxes		27,442.38
Due State Medical Society of Wisconsin		10,805.36
Current Portion of Mortgage Notes Payable		9,748.76
Total Current Liabilities		$ 55,601.59
Long-Term Liabilities		
Debentures Payable		$ 7,500.00
Mortgage Notes Payable	$541,729.12	
Less: Current Portion	9,748.76	531,980.36
Total Long-Term Liabilities		539,480.36
TOTAL LIABILITIES		$595,081.95
Capital		
Investment of State Medical Society		$ 150,245.96
Donated Capital		3,300.00
Reserves		130,815.97
Unappropriated Surplus		24,941.01
TOTAL CAPITAL		309,302.94
TOTAL LIABILITIES AND CAPITAL		$904,384.89

RECONCILIATION OF CAPITAL
Year Ended December 31, 1967

	Balance 1/1/67	Increase from Operations	Balance 12/31/67
Investment of State Medical Society	$150,245.96	$	$150,245.96
Donated Capital	$ 3,300.00	$	$ 3,300.00
Reserves			
For Repair and Maintenance	$ 32,486.74	$ 879.08	$ 33,365.82
For Return on Investment	59,520.00	10,000.00	69,520.00
For Funding Appreciation	21,930.15	6,000.00	27,930.15
Total	$113,936.89	$ 16,879.08	$130,815.97
Unappropriated Surplus	$ 16,085.29	$ 8,855.72	$ 24,941.01
Total Capital	$283,568.14	$ 25,734.80	$309,302.94

NOTE: On January 2, 1968 purchase of real estate at 914 Edgewater Court for $13,900.00, toward which this deposit was made, was completed.

Exhibit B

SMS REALTY CORPORATION

Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1967

INCOME		
Rental Income—Properties Owned		$265,195.00
Rental Income—Leased Properties		50,383.96
Dividends—Savings and Loan Accounts		1,426.95
Interest Earned		6,636.71
Gain on Disposal of Fixed Assets		1,583.07
Cafeteria Income		59,477.37
Other Income		331.94
TOTAL INCOME		$385,035.00
EXPENSE		
Maintenance Payroll	$ 47,362.78	
Managerial Services	14,562.71	
Internal Accounting	2,261.46	
Switchboard Services	9,285.13	
Employees Insurance	2,830.51	
Retirement Plan Contribution	2,179.82	
Payroll Taxes	3,508.30	
Repairs and Maintenance	9,120.92	
General Insurance	2,741.90	
Electricity	13,401.96	
Fuel Oil and Gas	5,286.35	
Water and Sewer	2,398.10	
Building Supplies and Expense	13,412.81	
Accounting Services	1,077.95	
Legal Services	928.51	
Telephone	12,079.43	
Depreciation, Net of Amortization of Improvements	36,879.19	
Property Taxes	27,442.38	
Interest Expense	26,659.77	
Miscellaneous Expense	8,915.95	
Amortization of Bond Premium	432.10	
Auto Expense	3,620.18	
Rental Property Expense	90.00	
Rental Expense—Leased Properties	50,383.96	

(Continued on next page)

(Continued)

Cafeteria Expense	59,477.37	
Total	$357,339.84	
Less: Portion of Above Expenses Recovered by Services Furnished to Others	2,003.36	
TOTAL EXPENSE		355,336.48
Excess of Income over Expense before Special Items and Reserve Allocations		$ 29,698.52
SPECIAL ITEMS		
Costs Reallocated from Prior Years		3,963.72
Excess of Income Over Expense		$ 25,734.80
ALLOCATIONS TO RESERVES		
To Reserve for Repair and Maintenance	$ 879.08	
To Reserve for Return on Investment	10,000.00	
To Reserve for Funding Appreciation	6,000.00	
Total		16,879.08
Balance to Unappropriated Surplus		$ 8,855.72

Exhibit A

CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION

Incorporated of the State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET
December 31, 1967

ASSETS			
Current Assets			
Cash on Hand			$ 669.59
Cash in Banks			27,148.16
Accounts Receivable			367.21
Pledges Receivable			600.00
Dividends Receivable			37.83
Accrued Interest Receivable			1,012.13
Unexpired Insurance			864.38
Total Current Assets			$ 30,699.30
Long Term Assets			
Notes Receivable—Student Loans	$157,414.87		
Less: Interest of Student Loan Fund in Notes Receivable	1,705.00	$155,709.87	
Common Stocks—Acquisition Value (Market Value $57,275.09)		26,130.82	
Savings and Loan Certificates		40,000.00	
Certificates of Deposit		11,000.00	
Total Long Term Assets			232,840.69
Fixed Assets			
Land, Buildings and Equipment—Net			140,796.19
Intangible Assets			
Organization Expense			160.00
Deferred Charges			
Deferred Expenses			1,518.51
TOTAL ASSETS			$406,014.69
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable		$ 521.16	
Sales Tax Payable		4.39	
Due SMS Realty Corporation		178.41	
Due State Medical Society of Wisconsin		20,778.22	
Accrued Interest Payable		68.76	
Total Current Liabilities			$ 21,550.94
Deferred Income			
Advance Receipts—1968 Income		$ 665.00	
Unallocated Contributions		80.00	
Waukesha Auxiliary Scholarship Fund to be Refunded		1,325.05	
Total Deferred Income			$ 2,070.05
Funded Liabilities			
Mortgage Notes Payable			30,000.00
Total Liabilities			$ 53,620.99

Capital

	Restricted	Unrestricted	
Balance—January 1, 1967	$264,403.01	$ 50,403.94	
Add: Capital Contributions	6,403.26		
Excess of Income over Expense	(10,101.92)	41,285.41	
Transfers	3,633.91	(3,633.91)	
Balance—December 31, 1967	$264,338.26	$ 88,055.44	
Total Capital			352,393.70
TOTAL LIABILITIES AND CAPITAL			$406,014.69

NOTE: Fixed Assets above are shown at values determined by appraisals of real estate and equipment and cost of additions purchased or constructed.

Exhibit B

CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION

Incorporated of the State Medical Society of Wisconsin
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1967

INCOME		
Contributions		
Restricted as to Use		$22,421.71
Not Restricted		25,191.71
Memorial Contributions		2,487.00
Total Contributions		$50,100.42
Other Income		
Fees for Scientific Teaching Activities	$ 1,615.75	
Museum Admissions	6,443.75	
Sales of Souvenirs and Jewelry	1,583.11	
Interest Income	3,087.02	
Dividend Income	2,076.09	
Gain on Disposal of Securities	5,443.80	
Miscellaneous Income	87.50	
Total Other Income		20,337.02
TOTAL INCOME		$70,437.44
EXPENSE		
Cost of Souvenirs and Jewelry	$ 1,405.08	
Museum Operations	31,537.01	
Charitable Assistance	350.00	
Equipment for Loan	14.00	
Scientific Teaching	6,745.12	
Stonefield Doctors Office	6,000.00	
Research Project on the Cardiac in Industry	1,550.00	
Past President Plaque	2,240.47	
Van Dusen Gravestone Restoration	472.29	
Gill Lamp	181.93	
Other Than CESF Projects	10.00	
General Administration	$ 10,399.34	
Less: Expenses Recoverable	1,615.23	8,784.11
TOTAL EXPENSE		59,290.01
Excess of Income over Expense before Special Item		$11,147.43
Special Item		
Expenses Recovered for Prior Years		20,036.06
Total Excess of Income over Expense		$31,183.49
Restricted		($10,101.92)
Unrestricted		41,285.41
Total		$31,183.49

NOTE: The Foundation classifies separately contributions received for projects in which capital is loaned or invested. Such contributions are not included above for 1967.

CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION

Incorporated of the State Medical Society of Wisconsin
Madison, Wisconsin

GENERAL COMMENTS

OBJECTIVE CLASSIFICATION OF EXPENSE
Year Ended December 31, 1967

Accounting Services	$ 1,471.75
Conference Expense	7,746.68
Promotion	3,772.36
Depreciation	4,306.97
Grants and Appropriations	7,765.00
Insurance	773.88
Employees Group Insurance	913.43
Legal Services	45.00
Miscellaneous Expense	1,684.12
Supplies and Expense	259.07
Outside Services	2,009.58
Payroll	15,924.90
Postage and Express	1,801.26
Printing and Forms	1,358.40
Rental of Equipment	65.04
Retirement	824.96
Social Security Tax	937.61
Federal Unemployment Tax	57.05
Wisconsin Unemployment Tax	127.31
Telephone and Telegrams	233.95
Travel Expense	1,341.03
Displays	505.79
Resource Material	150.00
Interest Expense	1,776.06
Purchases of Jewelry and Souvenirs	1,405.08
Repairs and Maintenance of Equipment	841.47
Utilities	2,067.87
Building Supplies and Expense	297.87
Loss on Fixed Assets	441.75
Total Expense	$ 60,905.24
Less: Expenses Recoverable	1,615.23
Net Expense	$ 59,290.01

STUDENT LOAN FUND

of the State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET
December 31, 1967

ASSETS	
Interest in Notes Receivable—Student Loans	$1,705.00
LIABILITIES AND CAPITAL	
Liabilities	$ None
Student Loan Fund Capital	1,705.00
TOTAL LIABILITIES AND CAPITAL	$1,705.00

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1967

INCOME	
None	$ None
EXPENSE	
None	None
Excess Income Over Expense	$ None

Exhibit A

EMPLOYEES' PENSION PLAN AND TRUST AGREEMENT

of State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET
December 31, 1967

ASSETS			
Current Assets			
Cash			$ 14,686.85
Accounts Receivable			1,177.99
Dividends Receivable			332.50
Accrued Interest Receivable			1,543.69
Due from State Medical Society of Wisconsin			162.30
U. S. Government Securities		$ 45,003.03	
Other Bonds		84,137.63	
Preferred Stocks		20,340.05	
Common Stocks		183,724.66	
Total Securities—At Cost		$333,205.37	
Adjustment to Market Value (Increase)		21,255.35	
Securities at Market Value			354,460.72
Savings and Loan Association Accounts			30,000.00
Total Current Assets			$402,364.05
Deferred Charges			
Deferred Investment Expense			108.33
TOTAL ASSETS			$402,472.38
LIABILITIES AND PRINCIPAL			
Liabilities			$ None
Principal—January 1, 1967		$309,484.36	
Employer Contributions	$ 48,972.89		
Less: Forfeitures Credited	1,573.19		
Net Amount Contributed	$ 47,399.70		
Employee Contributions	19,589.16		
Total Net Contributions	$ 66,988.86		
Fund Earnings	40,387.27		
Total	$107,376.13		
Less: Payments to Terminating Employees	14,388.11		
Net Increase		92,988.02	
Principal—December 31, 1967			402,472.38
TOTAL LIABILITIES AND PRINCIPAL			$402,472.38

NOTE: Securities are shown above at market value as required by the trust agreement. This treatment has been followed consistently since inception of the trust.

Exhibit B

EMPLOYEES' PENSION PLAN AND TRUST AGREEMENT

of State Medical Society of Wisconsin
Madison, Wisconsin

STATEMENT OF FUND EARNINGS
Year Ended December 31, 1967

INCOME	
Dividends—Common Stocks	$ 4,949.23
Dividends—Preferred Stocks	710.00
Dividends—Savings and Loan Accounts	1,411.95
Total Dividends	$ 7,071.18
Interest Earned	5,105.79
Gain in Market Values of Securities	29,461.27
TOTAL INCOME	$ 41,638.24
EXPENSES	
Investment Counsel Expense	1,250.97
NET FUND EARNINGS	$ 40,387.27

RECOMMENDATIONS OF REFERENCE COMMITTEE ON FINANCES—After reviewing the audit reports and meeting with a representative of the investment firm of Scudder, Stevens and Clark of Chicago, who submitted updated and current information with respect to the investment picture, the Reference Committee recommended continuance of such an annual portfolio review. It also commended the consultants who aided in its deliberations.

HOUSE OF DELEGATES ACTION—Accepted the Audit Reports as recommended by the Reference Committee.

SPECIAL MERIT AWARDS—Scientific exhibits which received special merit awards were: "Milwaukee Children's Hospital Juvenile Amputee Center," by Dr. Alfred E. Kritter of Milwaukee; "Terminal Nephritics Do Not Have to Die: Home Dialysis School at St. Michael and Deaconess Hospitals," by The Milwaukee Dialysis Association, St. Michael Hospital, and Deaconess Hospital with Drs. Frank E. Berridge, James A. Means, Andrew A. Pandazi, John T. Sullivan, Jr., and Lee H. Thompson of Milwaukee; "Carpal Tunnel Syndrome (Median Nerve Compression at Wrist Level)," by Drs. Jack L. Teasley, William H. Frackelton, and Donald M. Levy; and "The Pali and the Clas Systems," by Drs. Charles H. Altshuler, John Bareta, Anthony F. Cafaro, John R. Cafaro, and Glenn Fellows, PhD, in cooperation with St. Joseph's Hospital, Milwaukee.

■ REPORT OF WOMAN'S AUXILIARY—May 1968

MRS. DONALD M. BRITTON, Madison, President

I spoke yesterday to the Councilors, and this may be repetitious to many of you. However, I am glad to have this opportunity to speak to the House of Delegates. There may be value in repetition.

I have thoroughly enjoyed my year as President of the Auxiliary, and in my travels have found what wonderful wives you all have. Like your State Society, our first interest is in membership, for without members nothing can be accomplished. Our State has several unorganized counties which, if organized, could add hundreds to our membership. We hope all of you will encourage your wives to join the Auxiliary. If you doctors urge them, they will help to increase the effectiveness of the Auxiliary program.

We as doctors' wives are your public relations department. We have much competition in all civic organizations and other health-related fields. It would be to medicine's advantage if each of your wives projected herself into the community volunteer programs as medical Auxiliary members.

This year we have initiated a new policy. I hope you are familiar with the *Badger Doctor"s Wife*, our Auxiliary publication. It is now issued six times a year and is sent to all wives of State Society members. Invitations to this convention also have been sent to them.

As this year's representative of the Auxiliary, I want to express our appreciation for the additional funds you have provided. Besides better programing, this has allowed us to travel to forty-one different meetings in Wisconsin and adjoining states.

I will not take your time to evaluate our accomplishments. They are available to you in this report which has been provided for your information (see below).

Another advantage you have provided us is an Auxiliary office in the State Society building. It was greatly needed and is much appreciated.

SUPPLEMENTARY REPORT OF WOMAN'S AUXILIARY

Since health has become the nation's No. 1 industry, and the manpower shortage in the health fields has reached the critical stage, every organized county auxiliary in Wisconsin is concentrating on promoting careers in the allied medical fields. They sponsor health careers clubs, give scholarships, furnish literature to the high schools, cooperate with hospitals in arranging tours and teas for high school students, and train candy stripers.

On April 27, the State Auxiliary sponsored its first all-state Medical Careers Day. Approximately 200 juniors from 47 high schools attended. The schedule for the day started at University Hospitals, where students were able to tour the following departments: nursing, medicine, occupational therapy, medical technology, cytology, dietetics, pharmacy, X-ray technology, physical therapy and medical records.

At noon the students were transported by bus to the Society headquarters where a courtesy lunch was provided by the Auxiliary.

Highlighting the afternoon's program was an outstanding talk on "Scientific Horizons—Unlimited" by Dr. Robert Samp. Mrs. Virginia Cascio, a representative of the Madison Area Technical College, spoke on "Your Career as a Medical Assistant or a Licensed Practical Nurse."

County auxiliary scholarships for 1967–68 (from county reports we have at the time of this report) amounted to $15,000. The State Auxiliary awarded four $200 scholarships.

In addition to career activities, auxiliary members are busy sponsoring benefits for AMA-ERF, collecting sample drugs, making leper bandages and johnny coats for international health, mental health projects, home-centered health care, Indian affairs, legislation, safety, rural health, and in Madison and Milwaukee, the two WASAMA Chapters.

From all reports every doctor's wife is active in all phases of community activities, too numerous to list here.

When I was installed as president, I announced that my theme for the year would be HAVE GAVEL—WILL TRAVEL, and that I hoped to visit as many county auxiliaries as possible during my term of office. In most instances I traveled with Mrs. Sargent and Mrs. Chesemore.

Here's where we've been:

May 21–23: Illinois State Auxiliary Convention, Chicago
June 12: Waukesha County Meeting
June 18–22: National Convention, Atlantic City
July 19–20: Board Meeting, Madison
Aug. 7: Finance Meeting, Delavan
Sep. 13: Grant County Meeting, Platteville
Sep. 19: Convention Committee Meeting, Milwaukee
Sep. 26–28: Michigan State Auxiliary Convention
Oct. 3: Ashland–Bayfield–Iron County Meeting, Ashland
Oct. 4: Brown County Meeting, Green Bay
Oct. 8–11: National Conference of Presidents and Presidents-Elect, Chicago
Oct. 12–13: National Workshops, Chicago
Oct. 16–20: Work Week of Health, Madison
Oct. 25–26: Mid-Year Conference, Madison
Nov. 8–9: Northwest Regional Workshop, Rice Lake
Nov. 13: Dane County Meeting, Madison
Nov. 16: Racine County Meeting, Racine
Nov. 29: Finance Meeting, Milwaukee
Jan. 8: Dane County Meeting, Madison
Jan. 12: Milwaukee County Meeting, Milwaukee
Jan. 25: Fond du Lac County Meeting, Fond du Lac
Jan. 26: Careers Day Planning Meeting, Fond du Lac
Feb. 14: Scholarship Benefit Movie, Milwaukee
Feb. 20: Pierce–St. Croix Meeting, Baldwin
Feb. 27: Careers Day Planning Conference, University Hospitals
Mar. 2: Scholarship Benefit Fashion Show, Sheboygan
Mar. 13: Convention Planning Committee Meeting, Milwaukee
Mar. 18: La Crosse County Meeting, La Crosse
Mar. 25: Eau Claire–Dunn–Pepin County Meeting, Eau Claire
Mar. 28: Dodge County Meeting, Horicon
Apr. 8: Installation of Officers, Dane County Meeting
Apr. 11: Wisconsin Health Council Meeting, Madison
Apr. 15: Northeast Regional Meeting, Wausau
Apr. 22: Winnebago County Meeting, Neenah
Apr. 23: Rock County Meeting, Beloit
Apr. 24–25: Indiana Auxiliary State Convention, Indianapolis
Apr. 27: Medical Careers Day, Madison
Apr. 28–30: Iowa Auxiliary State Convention, Des Moines
May 1–2: Nebraska Auxiliary State Convention, Lincoln
May 7: Finance Meeting, Society Headquarters, Madison

"This is Our Best"

The following highlights from the county auxiliary reports point up what they consider the best of their efforts.

BARRON–WASHBURN–SAWYER–BURNETT—Sponsored a pre-school vision and hearing survey, a pilot program of the Minnesota Medical Society's Public Service Program for out-of-state usage. Contributed 32 johnny coats for World Relief. Administered ten $100 scholarships for the County Society.

BROWN—Met once a month for a "Knit-In" to knit leper bandages. Entertained the patients at Brown County Hospital every month. Have active careers club. Auxiliary chartered bus to bring students to Madison for Careers Day.

CRAWFORD—(smallest auxiliary) Has interest-free loans for needy students in health fields. Have helped some students through four years of school—no set amount—whatever individual may need.

DANE—Awarded 6 scholarships, 4 to registered nurses at $200 each and 2 at $100 for practical nurses. Gave $18.75 bond to Madison Area Technical College for award to deserving medical secretary. Contributed $800 to AMA–ERF.

DODGE—Sponsored baby-sitting Clinic in cooperation with the YMCA, a 7-week course for seventh graders. 39 graduated this year.

DOUGLAS—Entertained the blind of the County at a luncheon and program. Has 100% membership.

EAU CLAIRE–DUNN–PEPIN—Contributed $90 to Dunn County Hospital so thirty patients have $3 each to spend as they wish. Have active careers Club. Sponsor a careers day annually. Visited Mayo Clinic this year.

GRANT—Furnished materials for residents of nursing and county homes to make leper bandages. Contributed new and used clothing, books, puzzles, etc. to County Home.

LA CROSSE—Sponsored careers clubs in high school. Contributed lamp and sign to Sienna Hall (Halfway House). "The lamp is symbolic of the understanding and acceptance provided." Collected 225 lbs. of sample drugs.

LANGLADE—Organized and canvassed in Antigo for Mentally Retarded Fund and collected largest amount in history of the annual campaign. Has 100% membership. Sponsor monthly birthday parties for patients in Home for Aged.

MARATHON—Auxiliary arranged a series of six trips for the two special education classes of local high schools—24 students visited important places in Wausau. Sponsor two annual dances for this group, one of which is a prom.

MILWAUKEE—Contributed $4000 to AMA–ERF. Members entertain mental patients in their homes. 600 pounds of drug samples, soap and leper bandages were sent for world relief. Has Meals-on-Wheels program—64 Auxiliary members participate in delivering 50 meals a day to 25 patients. Sponsored premiere showing of "Doctor Doolittle" which netted $683.78 for scholarship fund. For the past three years Auxiliary members and student nurses staffed the Mid-West Flower and Garden Show. This year's profit of $1994 was divided among the nursing schools for scholarship funds.

OUTAGAMIE—Hostessing this year's convention is their most important project.

OZAUKEE—Members are writing a history of medicine in their County. Provide annual scholarship—help girl through all years of training.

PIERCE–ST. CROIX—Administer scholarships for the County Medical Society. Contributed articles for silent auction at Northwest Regional meeting, of which profit was given to AMA–ERF.

POLK—Has 100% membership. Contributed to Trempealeau County Home so patients could go Christmas shopping.

Woman's Auxiliary Art Show Winners

FIRST PLACE AWARDS

Mrs. Harold Rand, Milwaukee, *White Chrysanthemums*, oil.

Mrs. Marvin Wells, Milwaukee, *Faces Remembered*, watercolor.

Werner Hauschild, MD, Kenosha, *The Tower*, sculpture.

SECOND PLACE AWARDS

Maurice Hardgrove, MD, Milwaukee, *Oregon Coast*, oil.

John Erbes, Milwaukee, *Spruce*, watercolor.

Carol Ann Haller, MD, Milwaukee, *Gerry*, sculpture.

THIRD PLACE AWARDS

Guy W. Carlson, MD, Appleton, *Painting in the Ozarks*, oil.

Mrs. Kinge Hara, Wauwatosa, *Canyon*, watercolor.

Hania W. Ris, MD, Madison, *Gananum*, sculpture (cast bronze).

POPULARITY AWARD

John Erbes, MD, Milwaukee, *Spruce*, watercolor.

ART SHOW POPULARITY AWARD—Drs. James M. Sullivan of Milwaukee and David N. Goldstein of Kenosha view the watercolor painting, entitled "Spruce," which placed second in the show and won the popularity award. The painting is by Dr. John Erbes of Milwaukee.

STATE MEDICAL SOCIETY and American Medical Association dignitaries formed the receiving line for the President's reception before the annual dinner. Left to right: Dr. Harold J. Kief, Fond du Lac, outgoing SMS president; Mrs. Kief; Dr. Milford O. Rouse, Dallas, Tex., AMA president at that time; Mrs. Rouse; Dr. William D. James, Oconomowoc, new SMS president; Mrs. James; Mrs. Donald M. Britton, Madison, outgoing president of SMS Auxiliary; Doctor Britton; Mrs. Clifton C. Long, Ozark, Ark., president-elect of the AMA Auxiliary; Mrs. James Sargent, Milwaukee, new president of SMS Auxiliary; and Doctor Sargent.

RACINE—Health Careers program is their best. 200 high school students are active in careers clubs. Awarded $1,750 in scholarships. Contributed $2042 to AMA-ERF. Active in legislative activities.

ROCK—Gave $150 to Rock County Home for transportation fund for patients.

SHEBOYGAN—Sponsors annual fashion show for scholarship benefit, which is really "their best effort." Profit this year was $5,750.

VERNON—Donated radio to County Mental Hospital.

WALWORTH—Organize and train candy stripers for hospital.

WASHINGTON—Contributed $66 to Therapy Department of the County Home.

WINNEBAGO—Provided birthday gifts for 50 women patients at County Hospital. Donated four hair dryers at Christmas time. Auxiliary members staffed measles vaccine clinic. Furnished transportation for students who attended Careers Day in Madison. Mr. Salt was guest speaker at meeting at which "we learned about the activities of CESF."

■ REPORT OF STATE HEALTH OFFICER—May 1968

E. H. JORRIS, MD, Madison

In May 1966 at La Crosse I told you that we were in the midst of a social revolution—a time of change. During the two years that have elapsed, many changes have occurred which influenced the practice of medicine. You are only too well aware of these.

Many changes also have occurred in Wisconsin's public health program. I would like to review a few of these for you:

1—The seven-member State Board of Health has been renamed the Council on Health and serves in an advisory capacity to the State Health Officer and the Board of Health and Social Services. It retains the authority for the approval of rules coming under the jurisdiction of the State health agency.

2—The State health agency has been merged with the Department of Public Welfare and has been renamed the Division of Health, one of seven divisions of a new Department of Health and Social Services. This department functions under Mr. Wilbur Schmidt, the new secretary, and a new nine-member policy-forming Board of Health and Social Services. Dr. Harold Kief, Dr. Frank Drew and Dr. William Studley are members of this Board.

3—The State Health Officer is the administrator of the Division of Health.

4—New responsibilities assigned to the Division of Health during this two-year period include:

a—The certification of hospitals, nursing homes, home health agencies and laboratories for participation in Medicare, or Title XVIII.

b—The development of home health services throughout the State.

c—The development of an expanded quality control program for clinical laboratories, both in hospitals and in independent laboratories.

d—The drafting of regulations, inspection and licensing of residential care facilities.

e—The development and administration of State plans for the construction of community mental health centers and for mental retardation facilities.

f—The expansion of the Cytogenic Laboratory services in the Laboratory of Hygiene to assist in the diagnosis of mental retardation and other genetic defects.

g—To assist in the development of a diagnostic and treatment center for mentally retarded children at the Milwaukee Children's Hospital.

h—To arrange for the testing and collection of results of blood alcohol determinations in all cases of death involving a motor vehicle operator or a pedestrian sixteen years of age or older.

i—The designation by the Governor of the responsibility for the development and administration of a comprehensive health planning program for Wisconsin, including the encouragement of area-wide comprehensive health planning.

j—The designation by the Governor as the agency responsible for working with the Bureau of Census on official population estimates for the State.

k—The responsibility to promote and/or to provide for the immunization of all pre-school and school-age children against measles.

5—I would like also to bring to your attention changes that are planned for fiscal 1969 and 1970 for the Division of Health:

a—The Division has been assigned the responsibility for certification of all nursing homes, including county homes, county mental hospitals and public medical institutions for participation in Medicaid, or Title XIX.

Federal law requires that all nursing homes meet fully all requirements of the State for licensure by July 1, 1968 in order that the State continue to receive federal aid under Title XIX and certain other federal aid programs.

b—Under this same Act, Public Law 90-248 (HR 12080), there are many additional requirements which need to be met at future dates. By January 1, 1969 skilled nursing homes must meet the federal definition of a skilled nursing home. By January 1, 1970 all nursing homes must meet the provisions of the Life Safety Code of the National Fire Protection Association. Since all nursing homes now licensed by the Division of Health must either be of fire-resistive construction or sprinklered by July 1, 1969, this federal requirement should not pose any great problem. The State must also, by July 1, 1970, provide a program for the licensing of nursing home administrators.

In addition, this federal law provides that, effective July 1, 1969, in all nursing homes there shall be a regular program of medical review and medical evaluation of each patient's need for skilled nursing home care by medical review teams composed of physicians and other appropriate health and social service personnel, and that a similar plan of medical review be provided for patients in mental institutions.

In closing, I would like to express my appreciation to the great majority of physicians in the State Medical Society who have cooperated with the State Health Officer and the Council on Health in the conduct of our public health programs, particularly in the organization and operation of community programs for the immunization against measles.

As State Health Officer I have a responsibility to the people of Wisconsin to ensure that every child has protection against measles and will not be subjected to the danger of encephalitis and mental retardation. Sixty-two counties have had community immunization programs—ten have not. It is my sincere hope that the physicians in these ten counties will take the leadership and sponsor a community measles immunization program. The medical and nursing staff of the Division of Health stands ready to assist you; it will organize the program, provide the vaccine, and loan you a 50-dose jet injector. I am determined that every child shall have the opportunity to be immunized against measles, in one way or another.

I would also like to call to your attention that in the near future a vaccine for German measles will be licensed and available. Studies have shown that there is a close correlation between the incidence of German measles and the number of children born deaf, with eye and cardiac defects, or with other physical abnormalities. In addition, sample testing for antibodies of German measles in premarital blood specimens, made at the Laboratory of Hygiene, indicates that there are many susceptibles among Wisconsin's brides. It would, therefore, seem appropriate that when rubella vaccine becomes available, steps should be taken promptly to see that all female children and susceptible women in the child-bearing age be immunized against German measles.

REPORT OF THE STATE MEDICAL EXAMINING BOARD—May 1968

T. W. TORMEY, JR., MD, Madison, Secretary

The Medical Examining Board of the Department of Regulation and Licensing is presently involved with other licensing boards in the implementation of the Kellett Reorganization Program. The so-called routine housekeeping functions of the Board are being taken over by the Department. Usually at this time of the year we are mailing out the register of our licensees, but right now I cannot say when the register will be out. This year we estimate about 1,000 of our registrants wondered what happened to their checks; about 500 called or wrote to inquire; another 150 or more sent additional checks. This amount of confusion did not exist when we handled our own affairs. Hopefully it will improve. What worries me is that this is just the beginning of the implementation.

However, there are other and probably more vital concerns for the Board as a regulatory and licensing unit. The ad hoc committee of the SMS has been aware of needed changes in the Medical Practice Act, and several exploratory meetings have been held with them in this regard.

Among changes needed in the statutes and also in the routines of Board procedure are such items as clarification of the status of the foreign medical graduate and the problems of licensure in this field, limited licensure according to specialty training, the scope of temporary licenses, problems of reciprocity with other states, the qualifications and certification of certain allied medical personnel, and the problems of medicolegal responsibilities in the use of such auxiliary personnel. These and other facets of our function as an Examining Board must be explored and clarified.

With more medical schools turning to the organ system of teaching and the encouragement of the student to follow a more restricted interest in his studies and postgraduate training, it is apparent that a 19-subject comprehensive examination in so many phases of medicine is a manifestly unfair licensing procedure to a specialty trained individual. For instance, what does a certified neurosurgeon or E.N.T. man care or need to know about obstetrics, dietetics or some of the other subjects that we write?

For reciprocity purposes we conduct oral interviews of those applicants who qualify and hold full licensure in another state or who hold the National Board certificate. Some states, such as Michigan, Illinois and Kentucky, issue limited licenses, and we cannot regard these as full licensure for reciprocity purposes. This seems to cause some misundertanding on the part of applicants and those seeking their services. In fact, some such people try to influence our position by pressuring us through the offices of the Governor or the Attorney General or others. This is a nuisance for all concerned.

In the past years I have told you that our T.E.P. program for foreign graduate physicians has been filled. This year, in cooperation with the SMS Public Policy Committee, a bill was introduced in the Legislature to increase the allowed number of acceptances from 50 to 100 per year. In checking with the Governor's office as to the status of this bill, I was informed that it would probably be vetoed on the recommendation of an individual who was not fully aware of its background or importance. With some fancy footwork and fine cooperation from hospital superintendents and educators, letters were sent in supporting the bill. It was passed, and the program will be continued in a more effective manner.

Just for the record, our licensing examination and interview program since last May has involved 368 physicians. Of this group 358 were MDs and 10 were DOs. Of the 134 writing candidates, 66 were graduates of foreign medical schools. In this writing group 24 failed one subject and may rewrite it; 31 others failed two or more and will have the opportunity to rewrite the whole examination.

In this last group 25 were foreign graduates. A total of 124 subject failures were recorded. The subjects most often failed were Medical Jurisprudence, Materia Medica, Toxicology, E.E.N.&T., and Pathology.

We continue to lose 25 to 30 per cent of the foreign graduate physicians licensed. This is on an annual basis and in spite of their firm declaration of desire to practice in Wisconsin. Some of these go elsewhere in the United States and a number go back to private practice in another state or take their specialty boards or return to the V. A. program that requires licensure somewhere in the United States.

Complaints continue to come to us. While some are more properly referred to county grievance, SMS grievance, and other committees such as pharmacy, we see and check into problems in our province. Mr. Stordock has checked and reported on 29 new complaints and 10 held over regarding the medical profession and 11 involving quacks and paramedical violators.

Actions of the Board have resulted in two suspensions and two voluntary surrenders of licenses and narcotic permits. Applications for licensure were rejected in 6 instances after investigations.

Total registrations this past year are for 7,521 individuals.

M.D.s	4,698	(in state)
	1,739	(out of state)
D.O.s	248	
P.T.s	661	
Podiatrists	175	

REPORT OF THE DEAN, UNIVERSITY OF WISCONSIN MEDICAL SCHOOL—May 1968

PETER L. EICHMAN, MD, Madison, Dean

It is once again a pleasure to meet with you at your opening session for a third year.

The last year has been another year of great ferment in the health field. Changes are continuing at a fair pace and, in a general sense, we as physicians are responding in a manner which is responsible and constructive.

The policy position expressed by the House of Delegates of the American Medical Association regarding the support and expansion of medical schools and their educational programs was most welcomed by academicians in medicine.

At the state level, the vigorous support of the expansion and building program at the University of Wisconsin Medical Center expressed by your officers was most appreciated by me and the faculty of the University of Wisconsin Medical School.

The Wisconsin Regional Medical Program has matured over the last year and has developed a significant number of operational programs. Moreover, the Regional Medical Program has become a vehicle for much needed dialogue among practitioners, medical educators, and the public. It has been most pleasing to observe the constructive and sympathetic attitudes which dominate this interchange.

About one month ago, a new program was initiated. Comprehensive Health Planning has started in this state. Dr. E. H. Jorris and Dr. George H. Handy of the Division of Health are providing leadership. It is my view that this become another important forum of discussion and policy formation in programs of health care and facilities in this state. It is the intention of the University to cooperate and participate fully in this endeavor. It is also my personal view that communication and collaboration between the Regional Medical Program and Comprehensive Health Planning is paramount.

ELVEHJEM MEMORIAL LECTURE—Dr. David Yi-Yung Hsia, right, of Chicago accepted the Conrad Elvehjem Memorial Award from Dr. William D. Stovall of Madison following his lecture on "Genetic Factors in Pregnancy Wastage." The Elvehjem Award was established in 1962 by the State Medical Society to honor the life and work of Dr. Conrad Elvehjem who was internationally renowned in the field of biochemistry and was president of the University of Wisconsin at the time of his death. Doctor Stovall is president of the Society's Charitable, Educational and Scientific Foundation which administers the Elvehjem Memorial Fund.

In the coming year, I visualize a continued high level of collaboration between the University of Wisconsin and the practitioners of the state. The close work in postgraduate education between the State Medical Society and the University will continue at an even higher level. The growth rate in these programs has been very substantial over the last three to four years. It is also the intention of the University to address itself to a problem of great concern to many practitioners in the state—the problem of the family practitioner. We wish, as an educational institution, to review carefully our programs and especially our postgraduate programs in an effort to broaden the training programs. It is a very complicated problem and one which is frequently misunderstood.

The coming year may be the first year in which we start academic research into the problems of health services. There is a legitimate area of research and scholarly inquiry. This should be in keeping with the concerns expressed by our President, Doctor Kief, in his opening address this evening. We also expect to expand the allied health professional educational programs.

If there is a brief way of characterizing the theme for the coming year, it would be thus: We can accomplish much more together than separately —let us work together in the coming year.

VIETNAM VOLUNTEER PHYSICIANS—Four Wisconsin physicians who volunteered their services for 60-day tours in Vietnam during the fiscal year 1967–1968 were honored by the American Medical Association at the SMS annual meeting. Plaques were presented to, left to right, Drs. L. H. Lokvam, Kenosha; Isadore Schultz, Mazomanie; Thomas Beno, Green Bay; and Victor S. Falk, Edgerton.

REPORT OF THE DEAN, MARQUETTE SCHOOL OF MEDICINE—May 1968

JOSEPH W. RASTETTER, MD, Milwaukee, Assistant Dean

It is a pleasure to appear before the House of Delegates as a representative of Marquette University School of Medicine. I bring greetings from the students and from the faculty to the State Medical Society.

Dr. Gerald A. Kerrigan (Dean) regrets that he is unable to attend the meeting due to a conflict of work involving a meeting with the Legislative Committee of the State Legislature concerning Marquette School of Medicine.

I believe, in view of the many changes that are taking place in the field of medicine, we need even more cooperation between the medical schools of this State and the State Medical Society. Many of the things that Doctor Eichman has said I will not repeat, and I certainly would second many of the things he has said.

I assure you the Marquette School of Medicine will, as in the past, cooperate to the best of its ability with the members of the State Medical Society.

PRESENTATION OF AMA–ERF CHECKS—May 1968

WILLIAM D. JAMES, MD, Oconomowoc

Each year the AMA Education and Research Foundation solicits contributions from physicians and Woman's Auxiliaries throughout the United States for the purpose of aiding the medical education programs in each of the many medical schools of this country. As you know, the contributors may ask that their contribution be earmarked for a particular school or may give it without restriction.

This year the AMA–ERF has allocated a total of $8,576.57 to the University of Wisconsin Medical School as its share of both designated and undesignated gifts. The allocation for the Marquette University School is for $12,124.08. You should know that these funds are completely unrestricted as to their use.

On behalf of the AMA–ERF and the Charitable, Educational and Scientific Foundation of the State Medical Society I am very pleased and proud to present these checks to each of your schools, with the hope that the money will be useful in expanding and improving their programs of medical education.

PRESENTATION OF CERTIFICATES TO VIETNAM VOLUNTEER PHYSICIANS

On behalf of the American Medical Association, Dr. L. O. Simenstad of Osceola, AMA trustee, presented certificates to four Wisconsin physicians who had served volunteer duty in Vietnam this past year. The physicians are:

VICTOR S. FALK, JR., MD, Edgerton
LEIF H. LOKVAM, MD, Kenosha
ISADORE SCHULTZ, MD, Mazomanie
THOMAS BENO, MD, Green Bay

The certificates read: "Certificate of Humanitarian Service. Presented to (physician's name) by the American Medical Association in recognition of the meritorious service he performed for the medical profession, the United States government, and the people of South Vietnam, by treating the ill and injured during his medical mission under the AMA's volunteer physicians for Vietnam. /s/ Milford O. Rouse, President. (date of service)."

PRESENTATION OF JOHN H. HOUGHTON MEDICAL STUDENT AWARDS

WILLIAM D. STOVALL, MD, Madison, President of the CES Foundation

There is not a person in this House who knew John Houghton who does not feel respect and love for him. John was a person who loved to practice medicine, and he loved his contacts with his patients. He was patient with the complaints of his patients. So, we honor ourselves tonight and these two medical students, C. Robert Stanhope of Milwaukee and James W. Renne of Kenosha, when we confer an award to them which has been provided by John Houghton.

I would like to read a message to these students. We will say it is a message from John:

"Because Dr. John H. Houghton bequeathed to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin a fund for the creation of an award for deserving medical students;

"Because through his life he was dedicated not only to the practice of medicine as a science, but rather to the skill of the artful application of medical science in a spirit of humility, sympathy and compassion;

"Because his many friends among physicians and others out of affection for him have augmented his gift;

"Because you, by your accomplishments and behavior as students now present yourselves in a manner becoming to the kind of person Dr. Houghton visualized as a physician;

"Because the deans of your respective schools have recommended you to the Trustees of this Foundation as worthy of this award:"

The Board of Trustees have instructed me to convey to each of you through this award, including a $100 cash grant, their congratulations and, with it, their confidence that you will maintain the honor and dignity required of a physician, and that your sympathetic attention to the needs of your patients will merit their devoted and sincere friendship.

Let me introduce Mr. James W. Renne, senior medical student of the University of Wisconsin Medical School and Mr. C. Robert Stanhope, of Marquette Medical School.

This award has on it: "John H. Houghton, M.D. Award of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin." I congratulate you both.

COMMITTEE ON NOMINATIONS

The roll of Districts was called and the following members were nominated:

District	*Nominee*
First	W. G. Richards
Second	Morris Siegel
Third	John Morledge
Fourth	W. D. Hamlin
Fifth	J. F. Kovacic
Sixth	J. G. Bergwall
Seventh	John Satory
Eighth	Charles Koepp
Ninth	J. F. Bigalow
Tenth	L. O. Simenstad
Eleventh	Charles Picard
Twelfth	D. J. Carlson
Thirteenth	T. C. Fox

HOUSE OF DELEGATES ACTION—Accepted the Committee on Nominations as selected by each district in caucus.

REPORT OF COMMITTEE ON NOMINATIONS

C. J. PICARD, MD, Superior, Chairman

The following nominees were presented for positions in the State Medical Society as follows:

President-elect—R. E. Callan, MD, Milwaukee (to succeed W. D. James, MD, Oconomowoc).

Vice-speaker—T. J. Nereim, MD, Madison (to succeed himself for a one-year term).

Delegates to AMA (1969–1970)—J. M. Bell, MD, Marinette (to succeed himself); E. L. Bernhart, MD, Milwaukee (to succeed himself).

Alternate delegates to AMA (1969–1970)—James C. Fox, MD, La Crosse (to succeed himself); C. J. Picard, MD, Superior (to succeed himself).

HOUSE OF DELEGATES ACTION—Elected all nominees by unanimous vote.

SUMMARY REPORT OF 1968 ANNUAL MEETING WITH PICTURES

appeared in June issue at page 309

Council Minutes pertaining to these reports appeared in July issue at page 349

ELECTION OF COUNCILORS

Nominations for councilors were presented by the elected delegates of the county medical society or societies in the district which the councilor represented as follows:

District	*Nominee*
Third	M. F. Huth, MD, Baraboo (to succeed himself)
Sixth	J. E. Dettmann, MD, Green Bay (to succeed himself)
Seventh	E. P. Rohde, MD, Gainesville (to succeed James C. Fox, MD, La Crosse)
Eighth	J. W. Boren, Jr., MD, Marinette (to succeed himself)
Ninth	E. P. Ludwig, MD, Wausau (to succeed himself)
Tenth	Walton R. Manz, MD, Eau Claire (to succeed himself)
Twelfth	S. L. Chojnacki, MD, Milwaukee (to succeed himself)
	S. W. Hollenbeck, MD, Milwaukee (to succeed himself)
Thirteenth	Marvin Wright, MD, Rhinelander (to succeed himself)

HOUSE OF DELEGATES ACTION—Elected the nominees as recommended by the respective districts.

REMARKS OF SECRETARY

MR. C. H. CROWNHART, Madison

At your first session you heard from Doctor Fox. I think the staff would be remiss if it did not express to you and to Doctor Fox its very sincere appreciation for the wonderful service and cooperation he has provided for all these many years.

There was some indication in his remarks that he was resigning because of age. I haven't yet found a physician who resigns anything because of age. He is annointed within his profession and before the public.

Last night you had a presentation by Doctor Stovall. These things just don't happen, and I am sure Doctor Fox will continue his service, unofficially if not officially, to you members of the House and to your staff. My very deep appreciation for all the cooperation you have provided.

At this time I would like to make special note of the fact of Earl Thayer's return to the fold. He didn't resign either, really.

COMMITTEE ON CREDENTIALS

A. J. SANFELIPPO, MD, Milwaukee, Chairman
P. A. WAINSCOTT, MD, Menasha
W. F. SMEJKAL, MD, Manitowoc

HOUSE OF DELEGATES ACTION—Accepted as the official roll of the first session of the House 101 delegates, 8 alternate delegates, and 2 specially appointed delegates, totaling 111, entitled to vote, representing 46 county medical societies and 14 sections.

Accepted as the official roll of the second session of the House 84 delegates, 12 alternate delegates, and 2 specially appointed delegates, totaling 98, entitled to vote, representing 44 county medical societies and 9 sections.

Accepted as the official roll of the third session of the House 67 delegates, 9 alternate delegates, and 5 specially appointed delegates, totaling 81, entitled to vote, representing 38 county medical societies and 10 sections.

■ ATTENDANCE AT HOUSE OF DELEGATES—May 1968

SOCIETY:	Sessions 1	2	3
Ashland–Bayfield–Iron			
W. E. Bargholtz	o	o	o
J. M. Jauquet	x	o	x
C. A. Grand (Specially Appointed)	o	o	x
Barron–Washburn–Sawyer–Burnett			
C. J. Strang	x	x	x
Robert Anderson	o	o	o
Brown			
J. B. Grace	x	x	x
L. H. Edelblute	o	o	o
J. M. Guthrie, Jr.	x	x	x
Wallace MacMullen, II	x	x	o
Donel Sullivan	o	o	o
Henry Rahr	x	x	x
Calumet			
A. C. Engel	x	x	x
M. H. Klein	o	o	o
Chippewa			
M. W. Asplund	x	x	x
J. J. Sazama	o	o	o
Clark			
E. D. Pfefferkorn	o	o	o
T. N. Thompson	o	x	o
Columbia–Marquette–Adams			
R. R. Rueckert	x	x	x
R. T. Cooney	x	x	x
Crawford			
J. R. Wong	x	x	x
M. S. Garrity	o	o	o
Dane			
R. L. Beilman	x	x	x
R. W. Shropshire	x	o	o
G. A. Benish	o	x	x
C. Weir Horswill	x	o	o
J. V. Berger, Jr.	o	x	o
P. O. Simenstad	o	o	o
L. G. Crocker	x	x	o
G. B. Tybring	o	o	x
W. P. Crowley	x	x	x
J. J. Brandabur	o	o	o
G. J. Derus	x	x	x
E. E. Johnson	o	o	o
J. H. Morledge	x	x	o
P. G. Piper	o	o	o
J. F. Morrissey	o	o	o
Thomas C. Meyer	o	x	o
G. E. Oosterhous	o	o	x
J. J. Mueller	x	o	o
P. J. Schoenbeck	x	x	x
Arch E. Cowle	o	o	o
K. L. Siebecker	o	x	x
D. A. Peterson	o	o	o
H. M. Suckle	x	x	x
J. N. Moore	x	x	x
Dodge			
Wm. G. Richards	x	x	x
F. A. Karsten	o	o	o
Door–Kewaunee			
Patricia Lanier	o	o	o
W. G. Sheets	x	x	x
Douglas			
C. J. Picard	x	x	x
Thomas Doyle	o	o	o
Eau Claire–Dunn–Pepin			
A. A Drescher	x	x	x
G. G. Giffen	o	x	x
Ralph Hudson	x	x	x
T. D. Moberg	o	o	o

First name is delegate, indented name is alternate.
x—present, o—absent.

SOCIETY:	Sessions 1	2	3
Fond du Lac			
W. G. Kendell	x	x	x
Joseph Devine	o	o	o
D. J. Twohig, Jr.	x	x	x
Howard Mauthe	o	o	o
Forest			
B. S. Rathert	o	o	o
E. F. Castaldo	o	o	o
Grant			
C. E. Mueller	x	o	o
K. L. Bauman	o	x	x
Green			
R. G. Zach	x	x	x
W. J. Staab, Jr.	o	o	o
Green Lake–Waushara			
D. J. Sievers	o	o	x
S. L. Hadden	o	o	o
Iowa			
W. D. Hamlin	x	x	x
S. B. Marshall	o	o	o
Jefferson			
E. J. Netzow	o	o	o
M. G. Peterson	o	x	o
Juneau			
V. M. Griffin	o	o	o
Jack Strong	o	o	o
Alf Borge (Specially Appointed)	x	x	x
Kenosha			
Louis Olsman	x	x	x
F. C. Williams	o	o	o
Morris Siegel	x	x	x
G. F. Armstrong	o	o	o
La Crosse			
D. L. Morris	x	x	o
Frederick H. Wolf	o	o	o
G. B. Murphy, Jr.	x	x	o
Mark O'Meara	o	o	o
John J. Satory	x	x	x
Paul W. Phillips	o	o	o
Lafayette			
D. F. Ruf	x	x	o
R. E. Hunter	o	o	o
Langlade			
T. C. Fox	x	x	x
Dee W. Dailey	o	o	o
Lincoln			
R. J. Henderson	o	o	o
J. F. Bigalow	x	x	x
Manitowoc			
W. F. Smejkal	x	x	x
Raymond Yost	o	o	o
Marathon			
R. B. Larsen	o	o	o
J. D. Kramer	o	x	x
A. H. Stahmer	x	x	x
G. R. Hammes	o	o	o
Marinette–Florence			
C. E. Koepp	x	x	x
Antoine Barrette	x	o	o
Milwaukee			
E. L. Bernhart	x	x	o
J. D. Silbar	x	o	o
Robert W. Byrne	x	x	x
N. B. Hodgson	o	o	o
D. W. Calvy	x	x	x
D. K. Schmidt	o	o	o
D. J. Carlson	x	x	x
T. S. Buszkiewicz	o	o	o
W. L. Coffey, Jr.	x	x	x
W. H. Frackelton	o	o	o
E. G. Collins	x	x	o
H. R. Foerster, Jr.	x	o	x
T. J. Cox	x	x	o
R. F. Barta	x	o	x

SOCIETY:	Sessions 1	2	3
W. C. Curtis	o	o	o
R. C. Zuege	o	o	o
G. W. Dean	x	x	x
R. J. Snartemo	x	o	o
Norbert Enzer	x	x	x
R. H. Lillie	o	o	o
W. E. Finlayson	x	o	x
R. P. Le Tellier	o	o	o
G. F. Flynn	x	x	x
J. D. Hurley	o	o	o
T. J. Foley	o	o	o
C. P. Erwin	o	o	x
T. F. Jennings (Specially Appointed)	x	x	x
G. W. Hilliard	x	x	x
R. L. Franklin	o	o	o
P. G. LaBissoniere	x	x	x
F. L. Ziehl	o	o	o
Roger Laubenheimer	x	o	x
A. R. Pequet	o	x	o
F. J. Millen	x	x	o
W. V. Baker	o	o	o
G. V. Murphy	x	o	x
R. H. Frederick	o	o	o
J. R. O'Connell	x	x	o
W. J. Boulanger	o	o	o
R. B. Pittelkow	x	x	o
W. T. Atkinson, Jr.	o	o	x
Anne Roethke	x	x	x
R. R. Watson	o	o	o
F. A. Ross	x	x	o
L. L. Larsen	o	o	o
A. J. Sanfelippo	x	x	x
G. H. Franke	o	o	o
K. E. Sauter	o	o	o
M. E. Sattler	o	o	o
J. W. Sargent (Specially Appointed)	x	x	x
E. J. Schmidt	x	x	x
T. P. Borowski	o	o	o
J. T. Schmitz	x	o	o
John Bareta	o	o	o
J. J. Smith	x	o	o
D. E. Koepke	o	o	o
R. T. Sproule	x	x	x
Marvin Glicklich	x	x	o
W. L. Treacy	x	x	x
W. C. Webb	o	o	o
H. F. Twelmeyer	x	x	x
B. M. Zimmermann	o	o	o
L. R. Weinshel	o	o	o
T. L. Calvy	x	o	o
E. D. Wilkinson	o	o	o
D. P. Babbitt	o	o	o
R. F. Barta (Specially Appointed)	x	o	o
S. E. Zawodny	x	x	x
J. J. Frederick	o	o	o
Monroe			
R. G. Konicek	o	o	o
Jack Brown	o	o	o
Oconto			
R. D. Heinen	x	x	x
K. L. Strebe	o	o	o
Oneida—Vilas			
Marvin Wright	o	x	x
H. S. Ashe	x	o	o
Outagamie			
J. G. Bergwall	x	x	x
W. H. Hale	o	o	o
W. R. Richards	o	x	x
Ozaukee			
R. H. Dorr	x	x	x
J. F. Walsh	o	o	o
Pierce—St. Croix			
C. A. Olson	x	x	x
J. L. Craig	o	o	o
Polk			
L. O. Simenstad	x	o	o
M. E. Wegner	x	x	x
Portage			
F. E. Gehin	x	o	o
R. H. Bickford	o	o	o

SOCIETY:	Sessions 1	2	3
Price—Taylor			
W. W. Meyer	x	x	x
J. D. Leahy	o	o	o
Racine			
W. F. Henken	o	x	x
J. C. Fralich	x	o	o
W. J. Little	x	x	o
W. J. Smollen	o	o	o
W. H. Williamson	x	x	o
M. W. Nelson	o	o	o
Richland			
R. W. Edwards	x	x	x
George Parke	x	o	o
Rock			
R. M. Baldwin	x	x	x
C. M. Carney	o	x	x
Jordon Frank	x	x	x
Allen O. Tuftee	x	o	o
M. F. Purdy	x	x	x
J. R. Schroder	o	o	o
Rusk			
H. F. Pagel	x	x	x
Sauk			
John Rouse	o	o	o
Gerald Kempthorne	o	o	o
E. L. Weston (Specially Appointed)	x	x	x
Shawano			
Patricia J. Stuff	o	o	o
W. W. Grover, Jr.	o	o	o
Sheboygan			
J. F. Kovacic	x	x	o
R. M. Senty	o	o	o
I. L. Schroeder	x	x	o
G. J. Twohig	x	x	o
Trempealeau—Jackson—Buffalo			
E. P. Rohde	x	x	x
W. E. Wright	x	x	o
Vernon			
R. A. Starr	x	x	x
Thomas Boston	o	o	o
Walworth			
E. D. Sorenson	x	x	x
R. S. Galgano	o	o	o
Washington			
E. C. Quackenbush	x	x	o
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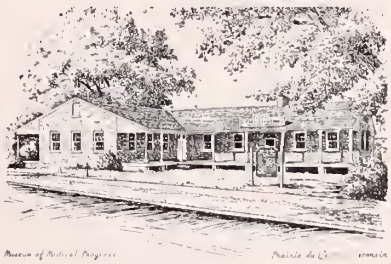

the wisconsin medical journal

VOLUME 67/NUMBER 10 OCTOBER 1968

Significant Clinical Manifestations of Molar Pregnancy

By FREDERICK J. HOFMEISTER, M.D. and WILLIAM O'LEARY, M.D.
Milwaukee, Wisconsin

■ EVERY DISEASE CAN, under specific conditions, present with a variety of clinical manifestations. The correct diagnosis can easily be determined and become quite evident when the disease is in its classical form. When presenting atypically, a correct diagnosis can become a difficult and stimulating adventure in medicine. The difficulty in arriving at an exact diagnosis is compounded if the suspected disease occurs infrequently. Hydatid mole is infrequently seen as a clinical entity. It is an enigma and can, therefore, create problems of diagnosis.

The incidence of hydatid mole varies greatly in different areas of the world. In a review of 157 cases in Formosa, the incidence was established as 1 in 82 pregnancies.[1] A seven-year survey revealed an incidence of 1 in 200 pregnancies in Mexico.[2] The incidence in Brazil was stated as 1 in 1000 pregnancies.[3] Hofmeister and Schwartz reviewed 374,204 pregnancies in 1964 and determined molar pregnancy as existing in 1 out of 2,295 pregnancies in Wisconsin (Table 1).[4] The incidence in the United States has been established as 1 in 2,500 pregnancies.[5]

The following abstracted cases are selected from 24 cases of hydatid mole which occurred at Lutheran Hospital, St. Luke's Hospital, St. Francis Hospital, and Milwaukee County Hospital during a period of time when 54,000 pregnancies were attended.

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Reprint requests to: Frederick J. Hofmeister, M.D., 2212 West State St., Milwaukee, Wis. 53233.

TABLE 1—*Incidence of molar pregnancy*

Number of pregnancies reviewed:	
350,308 Deliveries	
22,319 Abortions	
1,414 Ectopics	
163 Hydatid Moles	
374,204	
Incidence—1:2, 295 pregnancies	

The above statistics indicate the number of pregnancies in which 163 hydatid moles were diagnosed.

This is an incidence of 1 in 2,266 pregnancies and is consistent with that reported for Wisconsin and the nation.

Six cases were selected to illustrate the multiple clinical pictures which may complicate the diagnosis when molar pregnancy exists. The first two cases specifically illustrate the problem of coexisting toxemia as a common denominator.

Case 1 (Year, 1952).—A 26-year-old white woman, gravida II, para I, was admitted with amenorrhea of 3 months duration. Her entrance complaint was vaginal bleeding and spotting during the previous 4 weeks. There were episodes of severe nausea. The physical examination was essentially normal except for a blood pressure of 170/100 mm Hg. The uterus was compatable with an 18-week gestation. No fetal heart tones were audible. The pelvic examination revealed a long, thick, closed cervix. An ill-defined mass filled the cul de sac. There was no apparent edema. A urinalysis revealed 300 mg/100 ml of albumin. Due to the progressive deterioration of the patient, secondary to her toxic state, it was deemed advisable to empty the uterus. Her physician elected a hysterotomy rather than medical stimulation. A hydatid mole was removed. A luteal ovarian cyst filled the cul de sac and was permitted to remain. This is a common complication

TABLE 2—*Statistics*

Case	1	2	3	4	5	6
Age Race	23 W	36 W	19 W	26 W	26 W	20 C
G P	2 1	7 5	2 1	2 1	5 3	4 3
Duration of pregnancy	16 weeks	13 weeks	19 weeks	12 weeks	20 weeks	14 weeks
Bleeding	None	7 weeks	2 weeks	8 weeks	None	4 weeks
Toxemia	16 weeks	13 weeks	16 weeks	12 weeks	16 weeks	12 weeks
Epigastric pain	Yes	Yes	No	No	Yes	Yes
Size of uterus	+	+	+	+	O.K.	+

Pertinent statistics and prevalent symptoms are tabulated; all patients were multiparous. Bleeding occurred as early as two weeks and present in four of the six cases. Epigastric pain was present in four of six cases. Toxemia was a constant factor occurring as early as twelve weeks. Five of the six uteri were larger than the period of amenorrhea indicated. All pregnancies were terminated by the twentieth week.

of a hydatid mole. Luteal cysts will resolve if undisturbed and after the mole is removed.

Case 2 (Year, 1958).—A 36-year-old white woman, gravida VII, para V, Ab II, was admitted with a history of 2½ months amenorrhea. Her entrance complaint included mention of vaginal spotting for one month. The patient had been continuously nauseated. She indicated that she had been told that her uterus had grown too rapidly. The physical examination revealed a uterus compatable with a 4½ month gestation. Albuminuria and edema were absent. The hemoglobin was 9.4 gm/100 ml. During the next seven-day period, her blood pressure rose to 190/100 mm Hg. Edema and albuminuria deevloped and the uterus expanded to the size of a 5+ month gestation. Severe epigastric pain was noted. There was associated vomiting. A fetal skeleton was not detected by abdominal x-ray studies. The hemoglobin fell to 8.4 gm/100 ml without apparent blood loss. The cervix was dilated 2 cm. Explusion of the mole was completed with intravenous oxytocin (Pitocin) and dilatation and curettage.

Three interesting factors were noted in these two first trimester pregnancies. First, the triad of toxemia was present: hypertension, edema and proteinuria. If these symptoms had been present in the last trimester, the diagnosis of toxemia would have been elementary. However, this triad in the first trimester sends the clinician in search of other constitutional illness to explain these signs.

In 1928, Hitschmann stated that the early development of toxemia is one of the criteria which may be present in hydatid mole.[6] The association of toxemia and hydatid mole occurred in 26% of the cases in the Formosa series. The larger the uterus, the higher the percentage. When the uterus reached the level of the umbilicus, toxemia was present in 48%. In Mexico, toxemia and mole were related in 35% of the cases. However, in the Mexican series, there was no relationship to uterine size. Toxemia and mole were associated in our series in 25% of the instances.

Second, another interesting fact was that in both cases the uterine size was larger than usually expected from the period of amenorrhea. This observation is noted in 59% of the cases reported in the literature.[7]

Thirdly, a luteal cyst, an interesting phenomenon, was present in the first case. These cysts, due to the high titer of chorionic gonadotropin, were found in 23% of the cases.

TABLE 3—*Toxemia*

Case	1	2	3	4	5	6
Hypertension	16 weeks	13 weeks	16 weeks	12 weeks	16 weeks	12 weeks
Albuminuria	180 100 16 weeks	190 102 13 weeks	160 100 16 weeks	170 100 12 weeks	160 90 16 weeks	160 110 12 weeks
Edema	16 weeks	13 weeks	16 weeks		16 weeks	
Epigastric pain	15 weeks	13½ weeks			16 weeks	12 weeks
Nausea and vomiting	15 weeks	7 weeks	7 weeks	8 weeks	4 weeks	
Hematomegaly	Yes					

Existing symptoms relevant to toxemia are listed and their presence or absence noted. Hypertension and albuminuria were a constant factor in all cases.

Fig. 1—View of the large placenta showing hydatidiform degeneration and the associated edematous, abnormal fetus which is only one-third the size of the placenta.

The two following cases illustrate the coexistence of massive hydatidiform degeneration of the placenta with coexistence of a fetus.

Case 3 (Year, 1948).—A 23-year-old white woman, gravida II, para I, entered the hospital with a history of 4 months amenorrhea. She complained of upper abdominal pain for seven days. Her physical examination, ten days previously, was within normal limits. On admission, the blood pressure was 180/100 mm Hg. There was hepatomegaly. Two plus pitting was present. The uterus was palpable at the umbilicus. Laboratory studies revealed a 2+ albuminuria. The liver panel was normal. Her physician performed a hysterotomy because of her deteriorating physical condition. The result was the delivery of a placenta with marked hydatidiform degeneration and an associated 13.5 cm fetus.

Case 4 (Year, 1965).—A 26-year-old white woman, gravida V, para III, Ab I, was admitted with a history of 4½ months of amenorrhea. Her chief complaint was epigastric pain and anterior chest pain. She had gained 30 lb during these 4½ months. Ankle edema was recorded at 2+. The uterus was at the level of the umbilicus. Her blood pressure was 160/90 mm Hg. Placental souffle was present, but fetal heart tones were absent. There was a significant drop of hemoglobin from 10.6 to 7.8 gm/100 ml in two weeks. The bone marrow revealed erythroid hyperplasia. A roentgenogram of the abdomen revealed a fetal skeleton. The other laboratory tests were within normal limits. The presumptive diagnosis was the existence of a mole. A hysterotomy was performed. A placenta exhibiting marked hydatidiform degeneration was removed along with an edematous 20 cm fetus (Figs 1 & 2).

These two cases illustrate the difficulty in reaching the correct diagnosis when there is evidence of mole and fetal coexistence. Although the literature is vague, the incidence of coexisting fetus and hydatidiform degeneration is somewhere in the range of 1 in 37,000 deliveries.[8] In a Canadian review of 15 cases, there is a report of the survival of a term infant.

In 1964, Hobilay presented 10 additional cases,[10] one of which was a 6½ lb term infant. He claimed that 64% of molar pregnancies involved a fetus that was arrested in early development.

Another feature worthy of note in these cases is the presence of severe epigastric

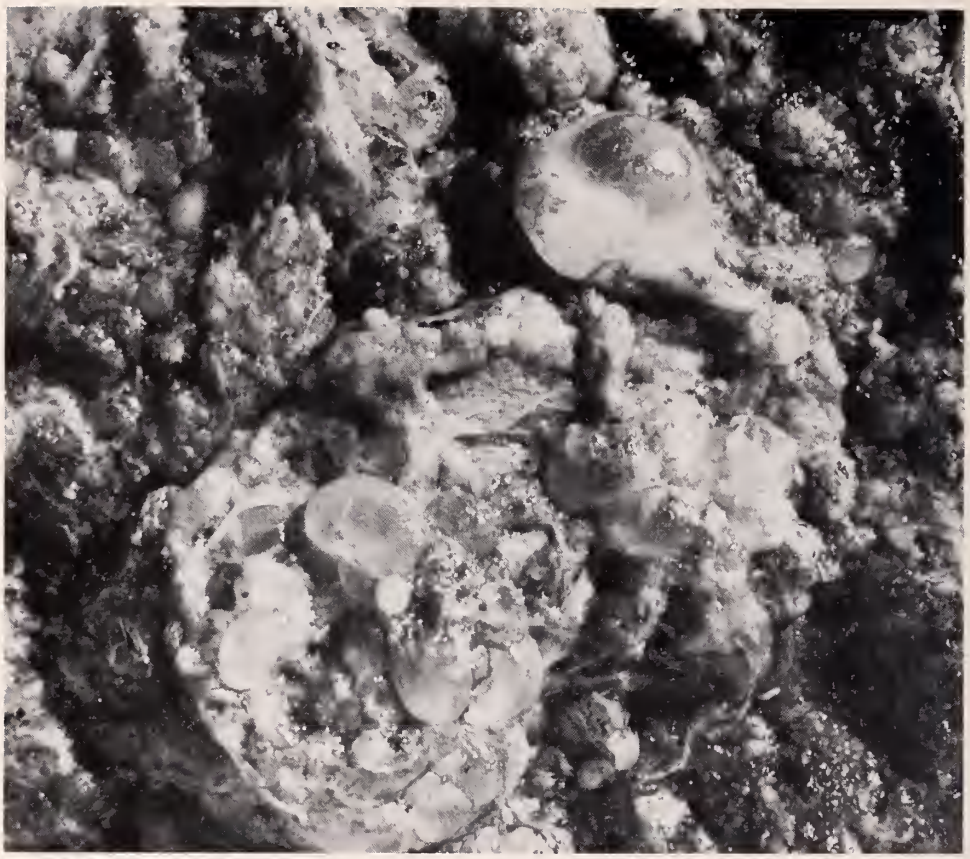

Fig. 2—This close-up view clearly reveals the degenerative process and the extent of involvement.

pain. Clinically, epigastric pain is often associated with toxemia but specific statistics are lacking. The anemia exhibited by the fourth case is not unusual. However, statistical support is not available for this finding.

Anemia out of proportion to blood loss was present in the majority of our cases and seems to be a clue to the presence of hydatid mole.

The following two cases have as their common denominator cardiac arrhythmia and pulmonary congestion.

Case 5 (Year, 1962).—A 19-year-old white woman, gravida II, para I, entered the hospital after 3 months of amenorrhea. Her entrance complaints were abdominal pain, vaginal bleeding, and severe nausea. The physical examination was within normal limits except for a hemoglobin level of 9.4 gm/100 ml. She appeared acutely ill on admission. However, symptoms resolved spontaneously and the patient was discharged from the hospital. She was readmitted one month later with a one-week history of edema, coughing, dyspnea, paroxysmal nocturnal dyspnea and orthopnea. The blood pressure was 160/100 mm Hg. Pulse rate was 140 and the respirations were 40. There was no venous distention. The lungs were clear to auscultation. The heart size was within normal limits. The rate was 140/min with gallop rhythm. There was 4+ edema. Her therapy consisted of oxygen, antihypertensive medication and digitalis. On the second day, she spontaneously passed the mole. The explusion was aided by intravenous administration of oxytocin, followed by dilatation and curettage.

Case 6 (Year, 1965).—A 20-year-old Negro woman, gravida VI, para III, Ab II, was amenorrhic for 3 months. She entered with the complaint of vaginal spotting during a two-month period. There was a sudden onset of abdominal cramps. The physical examination revealed right lower quadrant tenderness and a four-month-sized uterus. Twenty-four hours after admission, her temperature rose to 101 F. and the tenderness increased. On the second hospital day, she developed a pulse rate of 120. Blood pressure was 160/110 mm Hg. There was associated dyspnea and chest pain. Pulmonary effusion was demonstrated on chest x-ray film. Medical therapy consisted of digitalis, antidiuretics, and antibiotics. After seven days of observation, she spontaneously passed molar tissue. Explusion was completed by intravenous administration of oxytocin and a dilatation and curettage.

In both of these cases, it is apparent that the focus of attention could easily have been directed to the cardiac system. This is ex-

TABLE 4—*Laboratory findings*

Case	1	2	3	4	5	6
Anemia	No	+	+	+	+	+
Uric acid	3.2	—	—	—	10.5	—
Serum Friedman		1:5000	1:2000	1:1000		—
Urinary gonadotropin					1:256 1:4096	
Serum gonadotropin						651, 330

Pertinent laboratory findings existing in the abstracted cases are listed. Note the presence of profound anemia in five of six cases.

TABLE 5—*Associated findings*

Case	1	2	3	4	5	6
Hepatomegaly	+	—				—
Dyspnea			15 weeks		16 weeks	12 weeks
Congestive failure			+			+
Lutein cystoma				+	+	+

Associated complicating findings are listed.

actly what occurred until the presence of mole was determined and this pathology evacuated. The following diseases were considered in the differential diagnosis of these cases: viral myocarditis; pulmonary embolism; lupus erythematosis; subacute bacterial endocarditis and acute glomerulonephritis lupus.

Hydatid mole has a wide variety of clinical pictures with which it may present. It may mimic conditions as diverse as abortion; lupus erythematosus; gastrointestinal disorders such as pancreatitis, ulcer, and gallbladder disease; renal disease such as acute glomerulonephritis; and finally cardiac disease (Tables 2, 3, 4 and 5).

Summary

Prompt diagnosis, immediate treatment by evacuation, and accurate prolonged observation will result in immediate cure or will uncover any existent or potential malignancy. Specific therapy now exists which enables medicine to cope with choriocarcinoma when present.

However, as great a hazard as malignancy is failure to accurately diagnose mole and the resultant physical deterioration by toxemia, anemia, and circulatory failure. Confusion and this failure to diagnose accurately may result in the loss of a mother—a preventable maternal death.

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Culdoscopy at University Hospitals 1964–1967

Review of 100 Consecutive Cases

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■ VISUALIZATION OF PELVIC structures utilizing the culdoscope instead of pelvic laparotomy was introduced by Decker and Cherry[1] in 1944. Since that time there have been numerous reports of its use in the evaluation of various gynecologic problems.[2–8] At the University of Wisconsin Medical Center, culdoscopy was performed only sporadically prior to 1964. Since then, however, the technique has been employed with increasing frequency.

The present report is intended to describe our experience with 100 consecutive culdoscopic examinations performed at University Hospitals from July 1964 through November 1967 by ten staff gynecologists supervising ten senior residents. Sixty-six of the procedures were carried out under the direct supervision of three of the authors (G.E.S., W. K. and A.E.S.). The remainder were performed by staff and house staff physicians. In addition, we wish to outline in some detail our technique, which includes basal narcosis plus local anesthesia, and to emphasize the utility and safety of culdoscopy as a diagnostic procedure.

General Indications and Contraindications

We are in accord with most of the indications (Table 1) and contraindications commonly recorded in the literature.[1, 6, 7] First, culdoscopy has become virtually a routine part of our infertility examination; in this we disagree with Brown and Crocker[5] who found that "culdoscopy is of limited value in the investigation of infertility." We believe that culdoscopy can furnish valuable and sometimes essential added information in the total evaluation of the infertile couple. Second, we have frequently employed culdoscopy where the patient's symptoms were felt to be out of keeping with her pelvic findings. An example of this is the patient having pelvic pain with minimally abnormal, or even normal, pelvic findings; here culdoscopy may be used to establish or disprove the diagnosis of endometriosis. Third, we agree that culdoscopy is often helpful in the elucidation and evaluation of certain endocrine disorders such as the polycystic ovary syndrome.[5, 6] Last, culdoscopy may be useful both to identify and to clarify the nature of small pelvic masses or other obscure pelvic findings; this occasionally eliminates the necessity for laparotomy.

In our opinion significant obesity is a contraindication to culdoscopy, primarily due to the problem of positioning the patient. Second, cul-de-sac obliteration renders the technique both difficult and hazardous. Third, most conditions requiring surgery—large pelvic masses and suspected ectopic pregnancy for example—render culdoscopy unnecessary. Several authors[5, 6] have employed culdoscopy in the diagnosis of ectopic pregnancy but it is our feeling that if an ectopic pregnancy is seriously suspected, colpotomy is the preferable technique. In this instance, colpotomy affords better visualization and allows the possibility of excision via the vaginal route.

Method

Anesthesia. Some authors advocate general anesthesia for culdoscopy while others prefer various regional techniques. We have routinely utilized basal narcosis plus local anesthesia, a technique quite similar to that

TABLE 1—*General indications for culdoscopy*

1. Infertility.
2. Pelvic symptoms not in accord with pelvic findings.
3. Verification and identification of small pelvic masses.
4. Certain endocrine disturbances.

TABLE 2—*Medication schedule for culdoscopy*

Time	Agent	Dosage and Route
90 minutes before surgery	Secobarbital	200 mg oral
60 minutes before surgery	Meperidine	100 mg I.M.
	Scopolamine	0.4 mg I.M.
At surgery (if needed)	Meperidine	50 mg I.V.
At surgery	1% Lidocaine	Local infiltration and occasional paracervical block

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described by Billingsley and associates.[7] Our culdoscopies are done in the operating room at approximately 7:30 A.M., prior to the surgical schedule. This obviates surgical delay and preoperative medication can therefore be administered at a time scheduled for optimal sedation. Our medication regimen is given in Table 2, dosages being adjusted slightly on a weight basis. With this regimen, patients remain cooperative and, although minimally responsive, they have virtually complete amnesia for the entire procedure. Lidocaine 1% is injected at the point in the posterior cul-de-sac where the trocar is to be inserted.

Operative technique. We prefer to have the patient in the knee-chest position with the operating table placed in approximately 15 degrees of Trendelenburg. We have virtually no experience with culdoscopy performed in the dorsolithotomy position. It is essential that the abdominal wall be unsupported so that the abdominal contents will fall away from the pelvis, thus allowing effective visualization. The patient is supported on either side by stirrups padded with pillows. Padded shoulder braces are utilized to keep the patient from sliding forward on the table (Fig 1). It should be emphasized that proper positioning of the patient is the single most essential factor in successful examination. Our average time for culdoscopy is approximately 45 minutes, about one-third of which is devoted to positioning the patient.

Our operating table setup is shown in Figure 2. This includes equipment for dilatation and curettage and for evaluation of tubal patency. In recent years we have used the Clyman panculdoscope* exclusively.[9]

After the patient has been positioned, the vulva and vagina are cleansed with surgical detergent and water. Using a Sims speculum as a posterior retractor, the posterior (upper) lip of the cervix is grasped with a tenaculum forceps and, with tension on the tenaculum, the uterosacral ligaments are identified. The point of entry lies midway between the uterosacral ligaments. "Ballooning" of the vaginal apex behind (above) the cervix is sometimes demonstrated by having the patient cough or breathe deeply; this helps to rule out obliteration of the cul-de-sac. The point of entry is selected at or slightly ventral to the apex of the posterior vaginal fornix. The vaginal mucosa, subperitoneal tissues, and peritoneum are infiltrated with 1% lidocaine.

Fig. 1—Culdoscopy: positioning of patient.

Fig. 2—Culdoscopy: setup of table.

Next an 18-gauge needle with extender, attached to a 20 cc syringe without a plunger, is introduced through the anesthetized site into the peritoneal cavity, to produce a small initial pneumoperitoneum. The empty syringe produces an easily audible rush of air into the peritoneal cavity; this assures proper positioning of the cannula which is next introduced. The trocar is removed from the cannula allowing completion of the pneumoperitoneum, and the culdoscope, which has been heated in warm water

* National Electric Instrument Division, Engelhard–Hanovia Inc., Elmhurst, N.Y.

TABLE 3—*Age distribution of patients*

Ages	Number of Patients
15–20	8
21–25	39
26–30	29
31–35	16
36–40	4
41–60	4
	100

TABLE 4—*Indications for culdoscopy*

Indications	Number	
Infertility		63
Clomiphene Study	28	
Pelvic Pain		21
Suspected endometriosis	11	
Endocrine Disorders		11
Uterine Myoma—identification		1
Adnexal Mass—small		1
Pelvic Inflammatory Disease		1
"Rule out Carcinoma"		2
		100

TABLE 5—*Culdoscopic findings in 63 infertility patients*

Clomiphene Study		Other Infertility	
Endometriosis	2	Endometriosis	3
Polycystic ovaries	1	Polycystic ovaries	4
Minor adhesions	7	Adhesions	14
Negative	13	Negative	10
Failed	5	Hypoplastic ovaries	2
		Myomata	2
Total	28	Total	35

to minimize fogging of the lens, is inserted into the cannula. The examination is carried out in the darkened operating room. With a cervical cannula, methylene blue can be injected and patency of the fallopian tubes demonstrated under direct visualization. Prior to removal of the cannula, as much as possible of the intraperitoneal air is expressed, chiefly by means of manual pressure upon the abdomen. Suture of the cul-de-sac puncture site has not been required. If a diagnostic curettage is indicated, this can be done at the conclusion of the culdoscopy with or without additional paracervical block anesthesia. Of the present series, only seven patients required curettage, since most had previously had an endometrial biopsy.

Postoperatively the patients are returned directly to their hospital rooms. They are usually discharged from the hospital on the following day or, less commonly, on the night of surgery. Twenty-six patients in the present series were hospitalized for more than one day postoperatively, usually for completion of additional diagnostic studies.

Patient Material

One hundred consecutive culdoscopic examinations were evaluated retrospectively. It should be emphasized that 28 of these were carried out as a part of a clinical evaluation of clomiphene citrate in the therapy of anovulation (authors' unpublished data). All patients were hospitalized on the Gynecologic Service at the University Hospitals and none was acutely ill at the time of examination.

Age (Table 3). Patient ages ranged from 16 to 60. Because so many of our examinations were carried out to evaluate the pelvic viscera prior to clomiphene therapy, most of the patients were in the 20-to-30 age range. The primary indication for culdoscopy in the 15-to-20 age group was investigation of pelvic pain.

Specific indications (Table 4). Our chief indications for culdoscopy were infertility (63 cases, of which 28 were carried out prior to clomiphene therapy), endocrine disorders (11 cases) and pelvic pain (21 examinations). Of these last 21 patients, endometriosis was strongly suspected in 11 and culdoscopy was employed in an effort to establish the diagnosis.

Findings

Infertility. Within the group of 63 patients having a chief complaint of infertility, the 28 clomiphene-study patients were all anovulatory and exhibited various degrees of secondary amenorrhea. All 28 were thought preoperatively to have pelvic findings within normal limits, but 3 proved to have significant pathology and 7 more were found to have at least minimal adhesions (Table 4). Thirty-five patients underwent culdoscopy as a part of a routine infertility evaluation; 14 had tubal adhesions, in the main more significant than those in the clomiphene-study group, while 10 were negative for visible pathology.

Pelvic pain. Eleven of the 21 patients complaining of pelvic pain (Table 3) were thought preoperatively to have endometriosis. In these 11 patients, endometriosis was found at culdoscopy in only 5, another 5 had negative findings, and the last patient had

small myomata. For the remaining 10 patients in the pelvic-pain group, culdoscopic findings included "normal pelvis" (one patient), small myomata, and adnexal adhesions of varying extent. The relationship of these findings to the pain was not established.

Endocrine disorders. Eleven patients underwent culdoscopy to evaluate various endocrinopathies. Most of these had primary or secondary amenorrhea, with infertility not a presenting complaint. "Streak" ovaries were observed in 2 patients and polycystic ovaries in a third. No abnormalities could be identified in the remaining 8 patients.

Tubal patency. Evaluation of tubal patency with methylene blue was not carried out routinely. Our indication for this test was doubt concerning tubal patency, either at the time of tubal insufflation or on hysterosalpingography. Twenty-four methylene blue tests were performed during culdoscopy; 5 of these revealed bilateral tubal obstruction.

Correlation. In an effort to assess the diagnostic utility of culdoscopy in our hands, we considered the entire series of 100 examinations from one additional viewpoint: did culdoscopy alter the preoperative diagnosis in an appreciable number of instances? For the purpose of this simplified analysis, relatively insignificant postoperative changes in diagnosis (e.g. identification of filmy adhesions) were ignored, as were the specific preoperative and postoperative diagnoses. Figure 3 gives the result of this evaluation. The shaded bar represents 37 instances in which there were discrepancies between preoperative and postoperative diagnoses. In 11 culdoscopic examinations the findings were negative despite the preoperative impression of significant pathology, while in 26 examinations the culdoscope demonstrated clinically undiagnosed disease. Thus, following approximately one-third of the examinations the surgeon left the operating room with a significantly altered diagnostic impression!

Failures and complications. In 9 patients we were unable to pass the culdoscope into the peritoneal cavity. Two of these patients were excessively obese. The cause for six of the failures was not established; none appeared to be on the basis of cul-de-sac obliteration. Once the instrument was passed subperitoneally into the rectum; aside from several hours of careful observation no therapy was necessary and there were no adverse sequellae.

Nine patients were considered to have had complications of culdoscopy; none was directly related to the basal narcosis—local anesthetic technique. Four of the complications were probably associated with the position used. The patients complained of either weakness or numbness of an upper extremity, usually in the Erb's pattern. All of these neurologic changes were transient, most having cleared by the day of discharge; the longest Erb's paresis lasted approximately one month prior to full recovery. Two patients had postoperative fevers, thought to be due to chemical irritation of the peritoneum by dye in one instance and by blood in the other. Neither patient was treated with antibiotics and both were afebrile within one day. Two patients were briefly unable to void; no explanation was found for this unanticipated problem. One patient had unusually severe abdominal and shoulder pain postoperatively, probably as a result of inadequate expression of the pneumoperitoneum at the conclusion of the procedure.

Comment

In general we have been well satisfied by our experience with culdoscopy as a diagnostic aid. In the words of Billingsley *et al*[7] many physicians apparently believe that "there is no point in peeking through a keyhole when you can open the door." We concur that "by looking through the keyhole, we know which doors to open," and, what is perhaps more important, which doors to leave closed! In other words we feel that culdoscopy may at times be a very acceptable substitute for exploratory pelvic laparotomy.

We are in accord with Kelly and Rock[3] and Riva *et al*[4] that culdoscopy is a very helpful part of an infertility examination, especially in the absence of palpable pathology or when tubal reconstruction is contemplated. Normal culdoscopic findings are of particular value in the management of the patient with obscure pelvic pain in the absence of palpable pelvic abnormalities. Following culdoscopy the physician can assure such a patient not only that there is no palpable disease but also that there is no visible disease. Occasionally this assurance alone proves therapeutic!

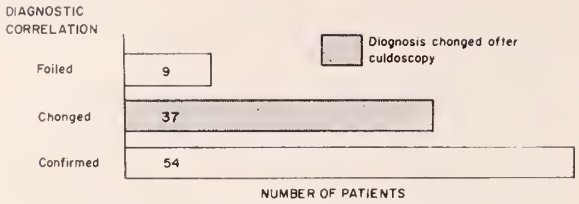

Fig. 3—Culdoscopic correlation of preoperative and postoperative diagnoses.

Our failure rate (9%) was high; we believe that this resulted chiefly from our lack of experience with the technique and can probably therefore be reduced. The hazard of transient injury to the brachial plexus can be minimized by care in placement of the shoulder braces and by limitation of Trendelenburg to 15 degrees. Alternatively, the dorsal lithotomy position may be employed[10] but this entails introduction of carbon dioxide gas under pressure into the peritoneal cavity in order to obtain adequate visualization.

As previously noted, we have employed neither the dorsal lithotomy position for culdoscopy nor the analogous technique of abdominal laparoscopy. These approaches are said to offer improved visualization and better opportunity for operative endoscopy—tubal ligation for example.[10] A simple addition to the technique of culdoscopy is the introduction of a malleable intraperitoneal probe through a second puncture site; Marshall[11] states that this "enables the operator to manipulate obstructing organs," thus greatly improving visualization. He terms his technique "dynamic culdoscopy." Finally, the relatively new field of fiber optics seems most likely to offer the next great advance in pelvic endoscopy. Here the light source is outside the instrument and is conducted to the instrument tip through light-carriers consisting of fiber optic glass bundles.[12] This will allow for much better illumination, both for still and moving pictures and for videotape recording.

Summary

One hundred culdoscopic examinations have been reported and evaluated.

Our technique has been described. Following culdoscopy our diagnostic impression was changed significantly in approximately one-third of the examinations. Our failure rate was 9%. No major complications were encountered. Culdoscopic examination is indicated for evaluation of: (a) the infertile patient, (b) the symptomatic patient without palpable pelvic abnormalities, (c) the asymptomatic patient with minimal pelvic abnormalities, and (d) the patient with certain endocrinopathies.

ACKNOWLEDGMENT: The authors wish to express their thanks to the several full-time and clinical members of the department who allowed inclusion of their patients and also to the resident staff of the department.

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The Many Facets of Dermatomyositis

By ARTHUR C. CURTIS, M.D., F.A.C.P., Ann Arbor, Michigan

■ DERMATOMYOSITIS is a relatively uncommon disease which occurs in both children and adults. In the former group little is known regarding its etiology. In the latter group there are some factors that relate in 50 percent or more instances to its cause.

It begins with a peculiar heliotrope-colored erythema and edema of the face, usually best seen in the periorbital region. Dermatomyositis has a tendency to affect groups of muscles, and the extraocular muscles may be involved with ptosis, nystagmus, as well as retinal hemorrhages and exudates. Soon telangiectasia involving minute vessels will occur starting in the lids and then involving the face, neck, and chest.

As the disease progresses fatigue, anorexia, intermittent low-grade fever and progressive as well as profound muscular weakness involving the muscles of deglutition, shoulder girdle, neck, pelvic girdle, and quadriceps groups—any one of which or all may occur. Early in the disease the muscles involved may feel "doughy" and tender. Later they become wasted and firm. Atrophy and telangiectasia of the skin with a poikiloderma-like appearance occurs on the face, neck, chest, and similar patches over the posterior nail folds, interphalangeal and metacarpal phalangeal areas, thenar and hypothenar eminences and the elbows and knees. Late in the disease, atrophy of the skin, scleroderma-like changes, and soft tissue calcification may be present.[1] Raynaud's disease may occur in the adult but rarely in children.

Dermatomyositis must be differentiated from lupus erythematosus, trichinosis, scleroderma, and scleredema adultorum. An occasional patient will have both dermatomyositis and one of the collagen diseases, such as systemic lupus erythematosus and/or scleroderma.

Presented at the 127th annual meeting of the State Medical Society of Wisconsin, Milwaukee, May 14–16, 1968.

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From the laboratory point of view there is little to help in either the diagnosis of the disease or the assessment of its activity.

There is a slight elevation of the sedimentation rate. The white blood cell counts are often normal or if elevated are only slightly so. There may be eosinophilia and hyperglobulinemia. Urinary excretion of creatine is usually increased and creatinine decreased, but all of these changes can occur in other conditions and are not a good index for either diagnosis or follow-up.

A muscle biopsy will give a positive diagnosis *if* the right group of muscles is chosen for pathological examination.

Electromyographic studies of the disease closely correlate with its evolution and may help in choosing a biopsy site. The determination of the serum glutamic oxaloacetic transaminase (SGOT) secondary to muscle destruction more closely correlates with activity than any other test, so it is the most useful of all in following the activity of the disease.

Other studies, such as the regurgitation of liquids or soft foods, can be determined by the x-ray of a barium swallow. Later in the disease soft tissue calcification may be visible and in some patients several years after recovery it may be quite extensive.

Although the mortality ratio of dermatomyositis in children and adults is the same, 26 to 50 percent, there are both similarities and differences between the two groups. About 20 percent of children will die within the first year; 30 to 40 percent will die within the first five years. Remissions and exacerbations of the disease are rare but do occur for reasons unknown.

The children with dermatomyositis who survive will have inactive disease within the first two years. Half will have severe contractures, muscular fibrosis, atrophic skin changes, and extensive calcification of soft tissues serious enough to restrict their activities.[2] Raynaud's phenomenon is rare in children but occurs in 10 percent of adults. Soft tissue calcification, although a good prognostic sign, is three times more common in children than adults but it often and continuously impairs function.

In adults the disease can be unrelentingly progressive or suddenly remissive. Stertz[3] in 1916 first reported the association of malignancy and dermatomyositis. Curtis *et al*[4] in 1952 studied a group of patients with dermatomyositis and found 18 percent with various forms of malignant disease. These studies included both children and adults. Treatment by x-ray or excision of a malignant tumor resulted in improvement or remission. In this study it was suggested that perhaps the "tumor's catabolic products may serve as an allergen initiating the disease."[5] Later Arundell *et al*[5] showed that if children were left out of such compilations since their disease is not related to neoplasia, the percentage having malignant disease in adults would be 50 percent or more. It had already been shown that in children malignant disease was not a precipitating factor by Roberts and Brunsting[6] in 1954 and Everett and Curtis[2] in 1957.

The etiology of dermatomyositis in the adult without malignancy is still unknown. Associated with malignancy are the interesting studies of Grace and Dao[7] and Curtis, Heckaman and Wheeler.[8]

Grace and Dao in 1959 reported a patient with adenocarcinoma of the breast and dermatomyositis. Aqueous extracts were made from the tumor, normal skin, subcutaneous tissue, and normal muscle. When the patient was tested to these extracts intradermally, the one from the tumor produced a strong, immediate reaction with a 1.5-cm wheal surrounded by a 3-cm zone of erythema in 20 minutes. The pooled normal tissue produced only a 0.5-cm of erythema. Passive transfer studies were then done on a volunteer by injecting intradermally 0.2 ml of the patient's serum into several sites on the forearm. Twenty-four hours later these sites were challenged with both the tumor and normal tissue extracts. A significantly positive reaction occurred only in the area where the tissue extract was injected.

Our own patient was a woman with an unknown thoracic tumor and dermatomyositis. The tumor, normal lung, and muscle were obtained during thoracotomy. The tumor was found to be a metastatic adenocarcinoma, probably from the large bowel. Complete upper and lower gastrointestinal x-ray studies and sigmoidoscopic examinations were repeated and again found to be negative. All tissues and the patient's sera were stored at —10 C until used.

Sterile aqueous extracts were made from the tissues collected and these were used for testing the patients after warming to room temperature. At the time of testing the patient was receiving 80 mg of hydrocortisone intramuscularly daily.

Examination of the skin reaction to the test materials was done at 5-minute intervals until there was a definite diminution of the size, intensity, and induration of the reaction. These sites were also checked at 24, 48 and 72 hours for any delayed reactions and all were negative.

The results of these tests are shown in Table 1.

A volunteer with the same blood type (A +) was chosen for testing. Into three sites on the right forearm 0.1 ml of the patient's unheated serum was injected intradermally. Into symmetrical sites of the left forearm 0.1 ml of normal serum which had the same blood type as the patient was introduced intradermally. These sites were marked with ink and 24 hours later were challenged by extracts of the tumor, normal muscle, and lung. Three additional unprepared areas were challenged.

The only injected site giving a strongly positive reaction was the area previously injected with the patient's serum and challenged by the tumor extract. The positive skin reaction in this area was of the immediate type response reacting a maximum size of 55 mm in 35 minutes and having a 12-mm area of induration and 4 + erythema. This reaction began to subside in 45 minutes. Delayed readings in 24, 48, and 72 hours were negative.

At autopsy 11 weeks after thoracotomy the primary lesion was found in the sigmoid colon. The difficulty in finding the primary lesion in some instances of dermatomyositis suggests that circulating antibodies may play some part in repressing its growth.

Treatment

Steroids are invaluable in suppressing the activity of the disease. In children where neoplasia is not a factor electromyograph results and frequent SGOT determinations will allow one to follow the course and activity of the disease. Cessation of steroids should not be considered until the latter test is within the normal range and then only if on tapering the steroid dose to none the SGOT remains within the normal range.

TABLE 1—*Skin reactions in patient tested with own tissue extracts*

Tissue Extracts	Site	Time (in minutes)	Total Size of Skin Reaction (diameter in mm)	Erythema* (+ to ++++)	Area of Induration (diameter in mm)
Tumor	Right forearm	30	25	++++	20
		60	15	++	10
Normal muscle	Right forearm	30	7	++	0
		60	4	+	0
Normal saline	Right forearm	30	0	0	0
		60	0	0	0
Normal lung	Left forearm	30	5	+	0
		60	3	+	0
Normal saline	Left forearm	30	0	0	0
		60	0	0	0

*Amount of erythema: +, light pink; ++, pink; +++, red, and ++++, dark red.
The tumor extract was the only one producing a strong immediate reaction, reaching its peak in 30 minutes and beginning to disappear in 60 minutes. There was 4 + erythema and 20 mm of induration and a total size of reaction of 25 mm.

In adults where the incidence of neoplasia is almost proportional to the age group in which the patient falls, a search for a neoplasm must be thorough. Steroids are invaluable regardless of the presence or absence of neoplasia. The removal of the primary source of the neoplasm leads to involution of the disease. Its recurrence often causes relapse. There is no specific neoplasm that causes dermatomyositis but the largest single type is an adenocarcinoma.

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LIMB PROGNOSIS IN LUMBAR SYMPATHECTOMY

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American Surgeon 34:303–308, 1968

Surgical lumbar sympathetic denervation was evaluated on the basis of one year prognosis of limb salvage in a series of 30 patients who were not candidates for a direct surgical approach of their arteriosclerotic occlusion. Diabetic patients were not included in this series. Since lumbar sympathectomy theoretically provides more oxygen for the metabolic needs of a compromised extremity, it was postulated that increased oxygen saturation in the peripheral blood flow would be more direct evidence of improvement of circulation.

A comparative study of these patients' pre- and postoperative skin temperatures, oscillometric measurements, and femoral arteriovenous oxygen saturation differences was correlated with limb salvage. In this series, 11 patients underwent amputation of involved extremity one year following lumbar sympathectomy. There was no correlation of skin temperatures and oscillometric measurements with limb survival or amputation. Femoral arteriovenous oxygen saturation differences showed no improvement in 10 of the 11 patients requiring limb amputation and in 3 of 17 who had limb salvage. However, 2 of 3 patients who had no a-v oxygen saturation improvement had developed compromising ulceration of the involved extremity and died of other disease before the end of the year follow-up.

Femoral arteriovenous oxygen saturation differences, pre- and postoperative, were of prognostic usefulness in predicting limb salvage in 28 of 30 (93%) patients clinically followed for one year. Femoral a-v oxygen saturation differences were a better indicator of collateral circulation improvement in compromised limbs in comparison to skin temperatures and oscillometric measurements. Oxygen saturation determinations can be done in an adequately equipped laboratory and are far less time consuming and apparently more accurate than skin temperatures and oscillometric measurements.

CASE REPORT

Cervical Pregnancy

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■ SINCE ITS DESCRIPTION by Rubin[1] in 1911, the true incidence and an exact definition of cervical pregnancy have been debatable. Various authors have set forth criteria for precise identification of this rare form of ectopic pregnancy. Paalman and McElin[2] presented a classification of lower uterine segment, isthmic and cervical implantations. A further sub-classification of the cervical implantations was based on whether the proof was anatomical, pathologic, or clinically suggestive.[3] The varieties, of course, must be differentiated from cervical abortions. However, it is generally agreed that a positive diagnosis may be made only by demonstrating placental tissue in close proximity to or invading cervical glands.

Whether the criteria of proof is quite rigid, as established by Schneider,[4] or more lenient, the number of reported cases continues to remain small. The following case report is presented to add to the experience in the treatment of this rare condition.

Case Report

A 31-year-old Negro woman, gravida 3, para 2, was admitted to the hospital in July 1966 because of profuse vaginal bleeding. Her last menstrual period had occurred seven weeks before and was of five days duration. The patient had experienced marked postcoital bleeding on two occasions within the past five days prior to admission. This bleeding was painless, bright red, and a bloody discharge had been noted intermittently since her last menstrual period. The patient had also complained of nausea and breast engorgement. History revealed that eight years earlier the patient had had a dilatation and curettage followed by a pelvic laparotomy for evaluation of a cyst of the right ovary. The cyst was removed and appendectomy performed.

On admission her temperature, pulse, and respirations were normal. Blood pressure was 120/80 mm Hg. Pertinent physical findings were confined to the cervix which revealed marked enlargement with bluish discoloration much more pronounced on the anterior lip. The external os was completely closed by fibrous adhesions, except for small openings at 3 and 9 o'clock (Fig 1). These measured approximately 2 to 3 mm in diameter. Black, necrotic tissue, suggestive of necrotic placental tissue, could be seen through the opening on the right. The uterine corpus was of normal size, shape, and position. The adnexa were not remarkable.

Initial hemoglobin level was 10.4 gm/100 ml; hematocrit reading, 32%; and white blood cell count, 6,720/cu mm with a normal differential count. Repeated Papanicolaou smears were negative for malignant cells. Both the A–Z and Gravindex tests for pregnancy were positive. Urinalysis was within normal limits. The chest film was interpreted as normal.

Another gynecological consultant was asked to see the patient. Both the consultant and the attending physician felt the lesion to be a neoplasm of hemangiomatous character, but with a possibility of cervical pregnancy. Because of the unusual character of the cervix and the history of bleeding, it was agreed that at least a biopsy was indicated to rule out neoplasia. Since there was a possibility of

Fig. 1—Edematous congested anterior lip of cervix containing the pregnancy with fibrous bands obliterating central portion of os.

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cervical pregnancy, preparation was made for the management of hemorrhage, including blood replacement.

The day after admission the patient was taken to the operating room for examination under anesthesia and a cervical biopsy. Under anesthesia pelvic findings were unchanged. A No. 5 Hegar dilator was placed under the fibrous band covering the cervical os, being introduced through the openings at 3 and 9 o'clock in a transverse fashion. The portion of the fibrous band overlying the dilator was then incised. This allowed the cervix to dilate spontaneously to about 3 cm, exposing a dark brown to black granular tissue mass attached to the anterior portion of the endocervix. This was friable and measured approximately 1.5 by 2.5 cm. An attempt was made to remove the tissue intact with ring forceps, but it fragmented during the process. At this point brisk bleeding was encountered. Both the upper and lower uterine segments were curetted in an attempt to control this bleeding, with only limited success. Sturmdorff sutures were placed at 12, 3, 6, and 9 o'clock. Figure-of-8 sutures were also in the lateral portions of the cervix to control the cervical branches of the uterine arteries. A large iodoform pack was then placed in the cervix and lower uterine segment. This was tied firmly in place with the ends of the sutures placed in the lateral margins of the cervix. Bleeding was adequately controlled with these measures. Since an estimated 500 ml of blood had been lost and there was a slight drop in blood pressure, one unit of blood was started. During the procedure the patient had received oxytocin (Pitocin) by intravenous drip with very little effect on the bleeding. The patient left the operating room in good condition.

Except for a temperature of 100 F on the first postoperative day, there was no morbidity. The pack was gradually removed over a two-day period without subsequent bleeding. The patient was discharged on the fourth postoperative day.

The microscopic sections of the removed tissue revealed chorionic villi, trophoblastic cells and an amniotic membrane surfaced by a single layer of cuboidal cells. It was in part necrotic and infiltrated with numerous lymphocytes. Diagnosis: products of conception.

Twelve weeks after the surgery the cervix was completely healed, clean, and well epithelized (Fig 2).

Fig. 2—Normal well epithelized cervix 12 weeks postoperatively.

Comment

Some of those reporting cervical pregnancies feel that the problem of severe hemorrhage has been over-emphasized. Schneider commented that much of the massive bleeding may have been associated with the cervicoisthmic variety of placentation. It must also be kept in mind that with massive trophoblastic invasion of the endocervical mucosa and stroma, early termination and massive hemorrhage might well result because of the predominantly fibrous and, therefore, noncontractile nature of the human cervix. The most significant symptoms noted in almost all cases were bleeding, usually becoming progressively more severe, often postcoital, and the absence of cramping pain. When such a group of symptoms are present with clinical findings suggestive of this entity, all preparation should be made for the management of severe hemorrhage.

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Therapeutic Dilemmas

No. 12 of a Series

Editor:

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These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

STATUS ASTHMATICUS

Moderator: HOWARD J. LEE, M.D.
Participants: DAVID M. GLASSNER, M.D.
DONALD SHAW, M.D.
DOUGLAS D. KLINK, M.D.
FREDERICK P. KRUMENACHER, M.D.
JOHN O. CHAMBERLAIN, M.D.

Dr. Howard J. Lee: It is our purpose this morning to present four cases of adult-onset asthma as indicative of the diverse aspects of the malady and the consequent variations in management. Adult-onset asthma is usually extremely debilitating and often a very serious affair. Three of our patients have been admitted to the hospital one or more times (one of them is currently in the house); one has not required hospitalization. Doctor Glassner will present the cases.

Dr. David M. Glassner: I shall omit particulars regarding these patients that do not pertain to our principal objectives today.

The first patient is a 35-year-old, tall, rather powerfully-built white male school teacher, who developed some wheezing while laying sod in his yard in the fall of 1964. Since that time he has been in continually progressing difficulty without seasonal pattern. In 1965, and three times since then, he has had nasal polypectomy performed, most recently in June of this present year, 1967. Severe unrelenting wheezing, accompanied by chest pain, has necessitated four periods of hospitalization: in January and October 1966, August 1967, and at present in early November 1967.

The events precipitating the present hospitalization were the following. On Halloween Sunday, October 29, he went out with his children, developed a bad cold, and presented himself in our office in status that required three or four hours of care with intravenous aminophylline and epinephrine injections. He was then sent home on antibiotics, mucolytic agents and increased corticosteroids, in addition to his routine medication that I shall mention in a moment. Then on Friday of the Teachers Convention (November 10), he went on a long family shopping trip in the cold air, and had to be hospitalized on the next morning with his typical severe wheezing, coughing, and chest pain. There was some crepitance in his neck due to mediastinal emphysema at this time, but I think the chest pain merely reflected the muscular efforts associated with the violent respiratory movements.

Prior to the time when this patient was first seen in our office, in late summer, 1967, he had been under various modes of treatment, including bizarre dietary restrictions and some sort of hyposensitization. When we first saw him he was taking 8 mg of methylprednisolone (Medrol) every second day, one oxtriphylline (Choledyl) tablet daily, potassium iodide tablets and two aminophylline-ephedrine-amytal (Amsec) capsules daily. He had also been carrying a Medihaler continuously during the past four years, one cylinder of which lasted from a week to a month.

Upon several occasions in our office we have found frank pus in the nose, evidence of pansinusitis and recurrent nasal polyps, and the patient has volunteered the information that the severity of his asthma parallels the degree of his nasal congestion. And even now, after a week of hospitalization under antibiotic and bronchodilator medication and postural drainage has cleared up his acute infection, he gets discolored material from his nose and brings up clear material from his chest.

Dr. Lee: Doctor Shaw, will you kindly show the x-ray films at this time?

Dr. Donald Shaw (Resident in Radiology): Here are the paranasal sinuses. The frontal sinuses (Fig 1) are almost opaque; their borders are irregular and not as clear-cut as usual, and there is probably an element of osteitis. The right maxillary sinus (Fig 2) is almost completely opacified, probably representing fluid, although an air-fluid level is not visible. The patient's extensive subcutaneous emphysema is clearly evident in this film (Fig 3) of the lateral cervical spine.

Dr. Glassner (resuming): This is a young man with a young family, and he must work. But we have not been able to keep him ambulatory with usual medication, even including larger dosage of corticosteroids than we like to use. We therefore feel that only sinus surgery will provide the relief that

Figure 1

Figure 2

is needed: the Caldwell procedure bilaterally and ethmoidectomies. This surgery will be performed on the right side next week. I am sure of one result when both sides have been done: he will never have nasal polyps again. We have never had a single instance of recurrent polyps in the more than 20 years that we have been having these operations performed on our patients. And since I have never seen a case of nasal polyps that did not have an associated sinusitis, I think that prevention of the recurrence of polyps will be achieved only by adequate control of the pansinusitis. It is our hope, also, that with this upper respiratory situation cleared up, we will be able eventually to manage the asthma without corticosteroids.

Figure 3

The second patient, a 42-year-old white woman, developed asthma ten years ago (1957), while suffering from Asiatic influenza. This seems to have been fairly adequately relieved through use of a Medihaler until early 1961, when a long series of episodes terminated with hospitalization elsewhere for what she was told was pneumonia. Then in April 1961 she had a bilateral nasal polypectomy performed. The family history was negative for the usual allergic maladies.

This lady had been a patient in our office for about a year, but I had never seen her personally until one January night in 1963, when it became necessary to hospitalize her in severe status. The history at that time revealed that she had been taking from 5 to 15 mg of prednisone (Meticorten, etc.) daily for an extended period of time, 4 to 8 Amsecs daily, 1 to 2 aminophylline suppositories of 0.5 gm daily, and using one or the other of three nebulizers, which she carried in her purse, 10 to 20 times daily. She had been confined to a chair at home from May of that year and had gone from a massive 184 lb to 205 lb at time of admission.

In the hospital, the usual medications were continued but two additional steps were taken: she was denied use of the nebulizers, and she was gradually taken off corticosteroids. Within two weeks her initially very poor pulmonary function had been dramatically reversed. Since that time she has had a polypectomy and ethmoidectomy. The polyps have not returned, she is managed without corticosteroids or nebulizers, and now leads a normal life.

The lessons to be learned from this case are the dire effects of really abusive nebulizer use, the

effectiveness of sinus surgery, and the fact that withdrawal after prolonged use of corticosteroids is possible. We are currently obliged to resort to antibiotics and 4 or 5 days of corticosteroids in this patient only when she contracts an acute respiratory infection.

The third patient is a 46-year-old white woman who has been in the hospital within the past year because of increasing respiratory congestion and coughing. These symptoms had seemed to be precipitated in gradual fashion about two years previously in association with the emotional trauma of the sudden death of her husband. From that time until we saw her she had been studied by another physician, who was hyposensitizing her to some unknown antigenic material; had her on various medications including Elixophyllin and potassium iodide; and several times weekly had her come to the office for use of the Bird respirator. Despite this therapy, and the use of nebulizers, the patient was unable to work and was very limited in her home activities.

Our study of her revealed a nonproductive cough, adequate pulmonary function, no evidence of atopy or clear-cut history of seasonal rhinitis; there was some neurodermatitis. We felt that we were dealing with asthma based on a tendency to chronic bronchitis, coupled with an infective type of rhinitis, and aggravated by too frequent reliance on nebulized medication; and we thought that discontinuance of this use of nebulizers, stopping her smoking, and early treatment of intercurrent infections, would adequately take care of the situation. We have succeeded well with this and have resorted to the use of epinephrine and other emergency measures only when acute attacks of hyperventilation or wheezing have been provoked by the acquiring of a head cold, or by sudden exposure to outside cold or something of that sort. This has been pleasing because the patient has rather severe bilateral glaucoma, and we have not liked to make routine use in her of some of the agents that would ordinarily be employed. But we have insisted on being notified early of the onset of an exacerbation in order to institute therapy quickly.

The fourth patient, a 53-year-old white woman, is interesting from two standpoints; first, that we have taken care of her asthmatic daughter from the age of 3, and second, that she herself began to wheeze, for no discernible reason, only last spring. She seemed worse on damp days, but otherwise the attacks were not patterned and they were easily relieved by the ephedrine-theophylline-phenobarbital combination (Bronchotabs). There were no nasal polyps. This patient had kept a cat in her home for the past three years, and after the daughter married and moved away, it was realized how important the cat had been in the latter's asthmatic picture since severe aggravation in symptoms coincided with her visits home. Study of the patient then revealed marked reaction to the cat and lesser reaction to other danders. The cat was disposed of and all symptoms have disappeared.

Dr. Lee: Thank you, Doctor Glassner. Are there questions?

A Physician: What is the incidence of a positive family history among asthmatics?

Dr. Lee: I really believe that too little is known about family histories—that is to say, that too infrequently do we have accurate information covering more than two generations—to provide satisfactory answer to that question. In allergic practice, however, we do have strongly the impression that the tendency to develop bronchospasm is transmitted.

Dr. Glassner: It seems to me to be a particularly frequent occurrence that an individual with asthma associated with sinus disease will have a near relative similarly affected.

A Physician: Reference has been made to adequate therapy when an asthmatic develops a cold. What is "adequate" therapy in such circumstances?

Dr. Glassner: The important thing is to get the patient to realize that, no matter how well he may have cleared up under usual measures, he is not cured, and that when his symptoms return or increase he probably has an intercurrent infection. The patient should be seen if possible at this time and his bronchodilators and expectorants increased. If the complication occurs during the winter, it is very important to have steam inhalations employed and to attempt humidification of the home. The maintenance of a patent nasal and bronchial airway, so that secretions are not retained, is of utmost importance. Antibiotic use is justified and, in many instances, a short course of corticosteroids.

A Physician: What antibiotics do you usually use?

Dr. Glassner: Tetracyclines, more frequently than any others. There is convincing evidence that chloromycetin is the superior agent in the really chronic patient who has smouldering difficulty all the time and repeated infections, but I am very hesitant to use it because of the toxicity record. Perhaps its superiority in allergic cases is due in part to an immunosuppressive factor in its action?

A Physician: Do viral infections precipitate an asthmatic recrudescence equally with bacterial infections?

Dr. Glassner: There is no doubt that they do, for these common colds, which are of viral causation, will precipitate a violent episode long before the secondary bacterial infection has occurred.

Dr. Lee: Whatever will cause respiratory obstruction, as the common cold will do quite considerably and quickly, in these individuals with the bronchospasm tendency, will initiate a recrudescence. And anything that will relieve the obstruction will dampen or stop the attack. A fine example of this is the abortion of an acute attack of asthma in a child by provoking vomiting, which is a pretty effective medical bronchoscopy.

A Physician: Is there any one sedative drug that is usually more effective than others in the asthmatic patient?

Dr. Lee: The fact that an asthmatic manifests anxiety and tension has always seemed to me a perfectly normal response to his respiratory difficulty. Furthermore, all of the sympathomimetic drugs—epinephrine, ephedrine, isoproterenol, etc.—increase this apprehension, as is well known. Of course one can sedate such a patient to any degree desired through use of sedative drugs, but I certainly like to avoid the respiratory depressants among them. In fact, if I am to sedate an asthmatic individual in an attack, I much prefer the old-fashioned innocuous paraldehyde to any of the barbiturates or newer synthetic substitutes. But actually my routine approach to the patient's anxiety is predicated upon the conviction that the best way to combat it is to control his dyspnea by all measures that we can direct toward that end.

A Physician: What about the antihistamines?

Dr. Lee: My experience, fully corroborating that of many other observers, is that the antihistamines are quite ineffective in adult asthma. Why they are more effective in children I do not know unless it is that histamine is less involved in the adult than in the child. It is worth bearing in mind, however, that most of the antihistamines are also hypnotic-sedatives, in the higher dosage range at least. Perhaps such use of one of them would be a way of accomplishing sedation with relative freedom from the type of undesirable side-actions that characterizes the barbiturate group.

A Physician: Is there such a thing as a pure emotion-induced asthma?

Dr. Lee: I think the person who has the inherent bronchospasm tendency can have an acute attack provoked by almost any type of insult—sudden hyperventilation during exercise; exposure to cold air; inhalation of fumes of some sort, such as from turpentine in painting; an emotional experience; and many, many other things. It must be realized that these patients have some degree of bronchospasm at all times. During a period where such a person says he's feeling fine, and there is no evidence of wheezing on chest examination, you will find during ventilatory function studies that administration of a bronchodilator will not only increase vital capacity but also maximum respiratory flow rate. In other words, his respiratory capacity is adequate for normal circumstances—but add an insult of any kind, including emotional trauma, and you collapse the house of cards. I recognize of course that there are cases of asthma in which an associated psychic element is quite evident; but I believe that in most such instances the neurosis or psychosis requires to be treated as such and not primarily for relief of the asthma.

Dr. Glassner: Another point to be made with regard to the use of a sedative or tranquilizer in the acute case in hospital, is that when you write an order for such a drug this gives the resident or someone else the license to have the dose repeated—which can precipitate something that one is not prepared for. I think that if one cannot relieve the patient's anxiety in any other way, the prescription of a drug in these cases may be admissible—but do not expect it to have a beneficial effect upon the asthma itself.

A Physician: I would like to hear Doctor Glassner's opinion of the use of nebulizers.

Dr. Glassner: Theoretically there is nothing wrong with this type of medication, and certainly the individual who wheezes only very infrequently upon unusual exposure, can use the nebulizers with good effect. But the average asthmatic is either sick for several months consecutively in a seasonal pattern, or gets into frequent trouble with intercurrent infections or other complications or exposures, and has a more or less constant need for a bronchodilator. The ingredients in the nebulizers provide too short action to afford satisfactory relief when used only once or twice daily, and so we find these patients using them 10, 12, 20 times a day.

This is bad, because the phenomenon of a decreasing response with increasing use has been reported many times since it was first brought to our attention by Benson and Perlman, 20 years ago (R. L. Benson and F. Perlman. *J. Allergy* 19:129, 1948). Furthermore, bronchial irritation, increased secretion and loss of ciliary action are induced; and with larger particles landing on isolated areas of the mucosa, there is actual ulceration, loss of cilia and epithelial exfoliation, as shown by Galgiani's group (J. V. Galgiani, F. Proescher, W. Dock and M. L. Tainter. *J.A.M.A.* 112:1929). Most of the young people who die of asthma today are doing so not from excessive use of corticosteroids but from suffocation resulting from excessive use of nebulizers.

Dr. Frederick P. Krumenacher: In the current issue of the *Journal of the American Medical Association*, a Boston group (I. Barda, H. Jick, D. Slone, B. Dinan, B. Gilman and T. C. Chalmers. *J.A.M.A.* 202:506, Nov. 6, 1967) has reported on drug usage in five hospitals in that city. Theophylline, in the form of aminophylline, was shown to be the preferred bronchodilator in four of the five institutions, ephedrine being favored only in the pediatric hospital. What is the moderator's experience with oral theophylline preparations?

Dr. Lee: I have stopped using them because I have never been able to produce a satisfactory clinical response without provoking more gastric irritation than the patient can tolerate. I much prefer rectal or intravenous administration. In the article to which you refer there was no statement of the form in which aminophylline was used, but I think it almost certain that tablets were not often prescribed.

A Physician: There was early reference to the fear of using effective barbiturate dosage. Some of us have equal fear regarding the use of corticosteroids. Could we have comment on this?

Dr. Lee: The use of corticosteroids for a short period in an acute case will reduce respiratory tract edema and bail the patient out more effectively than anything else available. Barring other contraindications, a four or five day course of this sort can be used with impunity. As for long-term therapy, well we have to make the penalty fit the crime. If persistent use of the corticosteroids is necessary to keep a patient economically useful, then it seems to me that we should have no more hesitancy than we would in committing a diabetic to the use of insulin. Indications are accumulating that patients can be on a corticosteroid regimen for 20 years without demonstrating clinical evidence of a cushingoid state. I am referring to dosage of 2.5 to 5.0 mg daily, in some instances only 2.5 mg every other day. It is a very interesting fact that much less corticosteroid is required to control asthma than to control rheumatoid arthritis. But mark you, please, this is not a matter of prescribing a large bottle of the tablets and "see me in six months." This therapy is most meticulously presided over.

Dr. Glassner: You can't generalize regarding dosage in this area. The first patient we described this morning had severe bronchitis, a great deal of edema, fatigue, dehydration, and the like and was put at once on 5 mg four times daily of prednisone. In some clinics he would have been started on 60 mg, and the dosage would have been pushed up higher and higher if he continued to do poorly. But this is unnecessary. We have *not* found in asthma that there is lineal relationship between dosage and clinical response. I am sure that by pushing up to 40 mg in this patient we would not have brought him around any faster. Dosage as high as 7.5 to 10 mg daily is rarely used by us for maintenance, and we do not have serious complications of the therapy. No one is happy about having these patients on corticosteroids, but there is a point of practicality in all this.

The third of this morning's group of patients, the one with glaucoma, was treated without corticosteroids, and was readied for discharge from hospital very much later than would surely have been the case had we thought it advisable to use the drugs.

A Physician: With reference to daily dosage of 2.5 to 5 mg of prednisone, I would like to ask Doctor Klink how much the normal adrenals put out in a day and what effect such dosage would have on the glands.

Dr. Douglas D. Klink: The normal adrenal cortex secretes between 30 and 40 mg of cortisol daily, equivalent to 6 or 7 mg of prednisone. If this amount is given in divided dosage of 2.5 mg three times a day, endogenous adrenocortical suppression will occur. But if the entire dose is administered in the morning, there will be much less suppression because little of the drug will persist after midnight to suppress endogenous cortico-

tropin (ACTH) release during early morning hours. If the people in whom you are using the low dosages have normal adrenocortical function, that is to say, they are not addisonian and stress quite normally—how is one to explain their ability to respond better to the administered drug in replacement amounts than to the product of their own adrenal cortices?

Dr. Lee: Some years ago, Rose and his group in Montreal showed that some of these individuals actually have decreased adrenal function and need replacement amounts of corticosteroid.

Dr. John O. Chamberlain: There seem to me to be a couple of possibilities. First, that these patients may be in chronic need and your dosage is just supplying the little more than they can produce at a particular time. Or second, that having been on corticosteroid medication for some time, they are no longer actually able to put out this 35 mg of cortisone daily, and therefore your therapy is just bringing them up to the equivalent of normal production. This latter possibility seems to me to be comparable to what occurs in thyroid disease. Many of the patients we see in our offices or elsewhere for the first time are taking ½ to 1 grain of thyroid daily, which does nothing more than shut off the production of their own thyroid glands. Until we get them up to at least 2 grains daily we are not getting therapeutic effect.

A Physician: How objective is the evidence that individuals on these low dosages of corticosteroids are actually obtaining effects?

A Physician: I can cite no studies of the matter, but can tell you of one patient of mine with pemphigus, in whom low dosage could be easily titrated against blister production. At 25 mg of cortisone blisters appeared, and at 37.5 mg they disappeared; this went on for years.

Dr. Klink: I have seen no evidence that people who really do seem to profit by these low dosages are unable to respond to physiological stress with normal pituitary ACTH output and adrenocortical stimulation before placed on cortisone. It appears that they respond to injected ACTH in normal fashion.

Dr. Lee: Just recently we saw in our office a young woman, whom we had had on low dosage of corticosteroids for five or six years, who had married in the late summer. She said, "I've never felt better in my life. Asthma and eczema all gone!" I said, "When did you miss your period?" And she said, "Last week." A few days ago her obstetrician confirmed the pregnancy.

Dr. Krumenacher: A most interesting article dealing with corticosteroid dosage appeared in the March 1967 issue of the *Archives* (W. McK. Jeffries. *Arch. Int. Med.* 119:265, 1967), in which the observer showed that all he was doing with low dosage was suppressing and then replacing the production of corticosteroids in patients who had previously been shown by plasma and urinary cortisol determinations not to be adrenal insufficient—and yet these patients, most of whom were rheumatoid arthritics, obtained good results from this treatment. Thus it seems that the beneficial effects of glucocorticoid therapy cannot be fully explained on the basis of the mere provision of an excess of corticosteroid.

Dr. Klink: In response to Doctor Lee's point concerning improvement during pregnancy, I doubt that this occurs secondarily to increased levels of plasma cortisol. Modern investigations indicate that increases in plasma cortisol during pregnancy are secondary to elevated transcortin with a corresponding increase in bound cortisol while the unbound portion remains unchanged. Thus free cortisol, which is supposedly the active form in plasma, remains as in the nonpregnant state. One might ask if there is some other hormone responsible for the improvement during pregnancy? What is the effect, Doctor Lee, of the oral the answer to the oral contraceptive question.

Dr. Lee: I only know that many asthmatic women are never as comfortable as when they are pregnant; and for that reason they tend to have large families. I do not know autogenous vaccine therapy?

A Physician: What is the value of nasal contraceptives on asthma?

Dr. Lee: I think that this is merely a form of foreign protein therapy. (Summarizing). This morning we have dealt with several of the numerous types of asthma that are encountered in a specialty practice and have dealt with matters of therapeutic adjustments in them. The place and uses of polyp and sinus surgery, sedatives, nebulizers, and corticosteroids have been particularly dwelt upon.

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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Treatment of Acute Leukemia in Children

By L. GILBERT THATCHER, M.D., Milwaukee, Wisconsin

■ THE DIAGNOSIS OF acute leukemia and the knowledge of a fatal disease in a child invokes a tremendous emotional response in the family and taxes the skill of the physician to provide a satisfactory consultative and therapeutic role.

The first important aspect of appropriate treatment for acute leukemia is accurate diagnosis. I stress this because it must be emphasized that there is no single or specific test for acute leukemia which will say without question, "yes, it is" or "no, it isn't." The most diagnostic test is the evaluation of the bone marrow aspirate. Replacement of the bone marrow with the immature or "blast" cell is the essential feature for confirmation of the diagnosis. To embark on a therapeutic program for acute leukemia implies that the physician has first fully satisfied himself of the diagnosis. To do otherwise, may leave irreparable emotional turmoil in a family, in addition to endangering the patient with prolonged chemotherapy if a mistaken diagnosis is made.

If possible, morphologic classification of the type of leukemia is advisable. When it can be clearly done, it provides some prognostic and therapeutic aid. Unfortunately, by present clinical means, it is often not possible to accurately classify childhood leukemia. In this country the bulk of childhood leukemias appears to be of the lymphoblastic (75%–80%) or an undifferentiated primitive cell type, often called "stem cell" or undifferentiated leukemia. Where monoblastic, myeloblastic, or erythroblastic types can be morphologically distinguished, their survival time and response to therapy as a group is considerably less than the usual childhood type. We will restrict our discussion to the lymphoblastic or undifferentiated type of acute leukemia.

It is not possible in this short discussion to present the many different therapeutic approaches being tried in centers across the country. Suffice it to say that intensive high dose drug administrations and various drug cycles and schedules are undergoing study. At present they cannot be recommended for general use, but may prove to prolong disease control. There are useful new drugs undergoing clinical trials and new approaches being tried whose final potential is not as yet realized.

For this discussion I will present chemotherapy and management information that can be accomplished in most general community hospitals.

Chemotherapy

Table 1 lists the currently available drugs with definite anti-leukemic properties. Dosage schedules are suggested, but may have to be individualized depending on toxicity.

The therapy periods are generally thought of in terms of (1) induction of remission and (2) maintenance of remission.

The following features are emphasized regarding these phases.

Doctor Thatcher is Associate Professor, Department of Pediatrics, Marquette School of Medicine, and Director of Hematology, Milwaukee Children's Hospital.

TABLE 1—*Currently available anti-leukemic medications*

Drug	Total Daily Dose	Route of Administration	Frequency	Side Effects (Evidence of Toxicity)
Prednisone	2 mg/kg	oral	3 divided doses (every 8 hr)	Weight gain, anti-inflammatory action, occasionally hypertension peptic ulcer, muscle cramps
6-Mercaptopurine	2.5 mg/kg	oral	once daily	Hematopoietic depression (leukopenia, anemia, thrombocytopenia), occasional gastrointestinal manifestations, hepatotoxicity
Amethopterin	0.6 mg/kg or 0.1 mg/kg	oral oral	twice weekly once daily	G.I. (mouth ulcers, diarrhea, vomiting) hematopoietic depression (leukopenia, anemia), occasional rash, hepatotoxicity
Cyclophosphamide	3 mg/kg	oral	once daily	Hematopoietic (leukopenia, anemia), hair loss, nausea and vomiting, hemorrhagic cystitis
Vincristine	.05 .07 mg/kg	I.V.	once weekly	Hematopoietic (leukopenia, anemia), hair loss, abdominal pain, constipation, neurologic loss reflexes, muscle weakness, paresthesias

Induction

1. The combination of prednisone with 6-mercaptopurine (Purinethol), vincristine (Oncovin), amethopterin (Methotrexate), or cyclophosphamide (Cytoxan) will produce a higher percentage (85%) of complete remissions than any of the drugs used singly (30%–60%).
2. The use of prednisone is restricted to 4 to 6 weeks of therapy because continued use has not been shown to prolong maintenance of remission. Thus long-term steroid side effects can be avoided without reducing the effectiveness of drug therapy.

Maintenance

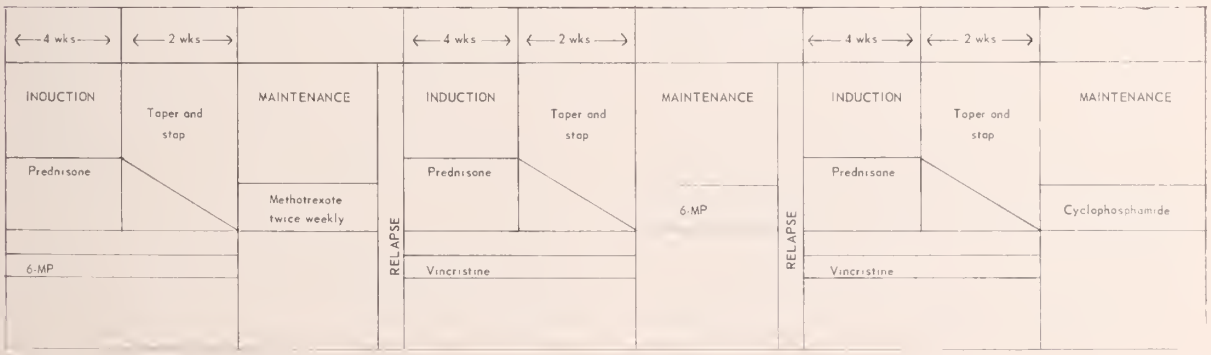
1. Prednisone and vincristine have not been useful in maintaining remissions and are best used during the induction phase.
2. Amethopterin, 6-mercaptopurine, and cyclophosphamide have shown definite activity in maintaining a remission.
3. Amethopterin seems to maintain remission longer when given intermittently (twice weekly), rather than daily.

Table 2 gives an example of a therapeutic program which can be managed in most communities and provides good use of the available drugs. Initial prednisone and 6-mercaptopurine induction could be interchanged with prednisone and vincristine depending on the physician's preference.

Some patients will not respond to all of the drugs or combinations and substitutions will have to be made. Dosages may be altered according to appearance of known toxicities.

Once remission is obtained the child should be followed at regular intervals (4 to 6 weeks) with hemoglobin and/or hematocrit, reticulocyte count, white blood cell count and differential, and platelet estimation or count. If suspicion of relapse is raised by clinical findings or hematologic changes, reevaluation of the bone marrow is in order. In general, 25% "blasts" recurring in the marrow denotes significant relapse and reinduction should be undertaken. Some centers suggest that the patient's progress be fol-

TABLE 2—*Example of drug therapy plan*



lowed by periodic bone marrow aspirations to ensure early detection of relapse.

Supportive Measures

Hemorrhage. During initial disease periods or time of relapse, thrombocytopenia is common and bleeding manifestations occur frequently. Fresh whole blood (20 ml/kg body wt) or packed red blood cells (10 ml/kg) can be administered to these children to maintain hemoglobin concentration above 6 to 7 gm/100 ml. If bleeding is uncontrolled, platelet rich plasma or platelet concentrates are often effective in temporarily controlling hemorrhage. Intramuscular or subcutaneous injections during these periods should be avoided and extensive local manipulations to control bleeding are best avoided.

Infection. Infection with common and uncommon organisms is a constant threat during periods of relapse. Careful attention should be paid to asepsis during procedures. Manipulations and procedures should be kept to a minimum if possible. Unexplained persistent fever in children in relapse on therapy should be explored carefully and the likelihood of sepsis be appreciated. Cultures, including blood cultures, should be obtained; and if the clinical picture suggests infection, high dose bactericidal antibiotics can be employed. If sepsis is suspected, the intravenous route of administration in maximal dosages is preferred. It is best to have adequate cultures before therapy so that specific antibiotic therapy can be employed as soon as possible. Recurrent broad spectrum antibiotic therapy is ultimately hazardous to the patient because of likelihood of developing a resistant bacterial or fungal infection.

CNS or Local Leukemic Involvement. The central nervous system (CNS) complication, characterized by leukemic meningeal involvement, occurs at some time during the course of the disease in 30% to 40% of these children. They usually present with headache, vomiting, meningeal signs, or other evidence of increased intracranial pressure. Spinal fluid is under increased pressure with elevated protein. Mononuclear cells are present in increased number (blasts if looked at carefully by smear). These episodes may often be recurrent (in spite of therapy) and can occur when the child is in hematologic remission.

Occasionally, local leukemic involvement may occur elsewhere, for example, the testis. Hematologic reevaluation should be done with local or CNS involvement as they may also herald early relapse. X-ray therapy to the local lesion, or skull and spinal axis for CNS involvement may be beneficial in providing temporary control. Methotrexate (0.3 to 0.4 mg/kg body wt) given intrathecally every 3 to 5 days until the cell count in the spinal fluid falls near normal is usually effective in controlling the CNS complication. CNS involvement is usually recurrent, however, and additional intrathecal methotrexate therapy will be required and is usually effective for control.

Hyperuricemia. On occasion large numbers of leukemic cells are rapidly lysed by therapy. Severe hyperuricemia develops and uric acid nephropathy and renal tubular shutdown may occur. Patients particularly with high white blood cell counts and extensive leukemic involvement (marked adenopathy, hepatosplenomegaly) should be considered likely candidates. To reduce the likelihood of occurrence, high fluid intake and alkalinization of the urine should be undertaken. Of considerable aid in such patients is the xanthine oxidase inhibitor, allopurinol. This drug blocks the formation of uric acid and allows for excretion of uric acid precursors which are more soluble and less likely to precipitate in the kidney tubules. Allopurinol can be used during the first days of the induction period at dosage of 50 mg, three times daily for children under seven years and 100 mg, three times daily for children over seven years. It should be remembered that if the child is on purine analogues (6-mercaptopurine) the excretion of these drugs is delayed by allopurinol and 6-MP dosage should be reduced by 75% during the time of therapy with allopurinol.

Emotional Needs

This aspect actually represents the most important part of the current therapy for acute leukemia. The physician must recognize the needs of the patient and his family and be willing to provide adequate consultation and facilities for proper care. Above all, he must be willing to spend significant amounts of time with the patient and the family to broach the many emotional needs created by this devastating disease. The demands of "friendly advice," "cure" articles in the general press, the frequent guilt feelings of parents, and the many other day by

day problems presented by the knowledge of fatal disease, are often overwhelming to the patient and particularly the family. Only by careful attention to these problems, compassion on the part of the physician, and an acceptance of the time committment to the patient and family that is required, will it be possible to render the type of care over the total disease period that is satisfactory to all concerned.

Many patients may wish to be cared for at centers to insure themselves of further consultation, and for the participation in new experimental therapy programs. Two centers in Wisconsin are participating in national cooperative childhood cancer programs. These programs are under the auspices of Children's Cancer Group A and are sponsored by the National Institutes of Health. They provide several new protocol studies and management programs. These are geared to provide further information and improvement upon present therapeutic approaches and are also testing new, potentially useful, therapeutic agents. Consultation or referral is available at Marquette School of Medicine at Milwaukee Children's Hospital, Milwaukee, or the University Hospitals, University of Wisconsin Medical School, Department of Pediatrics, in Madison.

SUTURE REINFORCEMENT OF THE INCOMPETENT CERVIX

F. J. HOFMEISTER, MD, W. R. SCHWARTZ, MD, B. F. VONDRAK, MD, and W. E. MARTENS, MD, Lutheran Hospital, Milwaukee, Wis.: *Amer J Obstet Gynec* 101:58–65 (May 1) 1968

A double suture modification of the McDonald technique to correct cervical incompetence in pregnancy was used on 44 patients at Lutheran Hospital of Milwaukee from 1958 through 1966. These 44 patients were sutured in 72 pregnancies. Prior to the first suturing of the cervix, the group as a whole had a 25% successful pregnancy outcome when first trimester spontaneous abortions were deleted. Following the operation there was a 63% successful pregnancy rate. Emphasis was placed on the importance of accurate diagnosis with the necessity of first eliminating other causes of abortions and prematurity.

The diagnosis was established by a history of repeated, painless midtrimester abortions or observing the protrusion of membranes through a partially dilated cervix without uterine contractions during the midtrimester. Various methods to diagnose the condition in the nonpregnant state were described but were not used in this series. Twelve patients had a history of previous extensive cervical trauma and an additional 8 reported an earlier dilatation and curettage. The remaining 24 offered no history of significant cervical injury and were classified as being "functionally" incompetent.

The operative technique employed consisted of placing a strip of Mersilene suture at the level of the internal cervical os with bites at 12–9–6 and 3 o'clock positions. A second strip was placed approximately one centimeter proximal to the first with bites at 10–7–5 and 2 o'clock positions. In most cases supplemental progestational agents and occasionally isoxsuprine hydrochloride (Vasodilan) were also used. The ideal timing of the operation is at 12 to 14 weeks gestation for three reasons: (1) first trimester abortions due to defective ova, faulty implantation, and the like are eliminated, (2) the placenta is well established, and (3) the operation is not technically difficult and there is less chance of nicking the membranes or starting an amnionitis if effacement and dilatation has not occurred.

The operation may be repeated in future pregnancies as evidenced by 9 successful repeat procedures. One patient has three successful outcomes. When successful, the sutures were left in place until the 38th week and then removed to allow for spontaneous labor or induction. Delivery was vaginal in 73% and by Cesarean section in 27%. Additional obstetrical indications were usually present in those delivered by Cesarean section.

The major contraindications to suturing are infection, ruptured membranes, bleeding, and labor. Failure to recognize any of these complications prior to or after suturing can lead to serious hemorrhage; possible septic shock and secondary sterility. These hazards are illustrated by specific cases. Failure to recognize premature labor and immediately remove the sutures can lead to further cervical injury. The authors agree with Mann who feels that cervical incompetence is a complex clinical entity, the cause of which is not always certain, the diagnosis of which is not always easy, and the management of which is not always simple.

PAMPHLET: LEUKEMIA, LYMPHOMA, AND MULTIPLE MYELOMA

Single copies (PHS Publication No. 1768) are available without charge from the Department of Health, Education, and Welfare, Washington, D. C. 20402. The pamphlet may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402 at 10 cents a copy or $5.00 per 100 copies.

FOR YOUR INFORMATION . . . from the Division of Health

SPOROTRICHOSIS

Beginning in May 1968, a series of cases of lymphatic sporotrichosis have been reported in relationship to tree packing and planting. The involved trees originated at the Hayward State Nursery, Hayward, Wisconsin.

The condition was brought to the attention of physicians in the area by Mr. John E. Borkenhagen, Nursery Manager, Department of Natural Resources, Division of Conservation, who recognized the problem. He had had prior experience with the disease some years ago.

Eight culturally positive cases were identified by Miss Lucille Goggin, Microbiologist at the State Laboratory of Hygiene. Two additional cases were proven by culture in Minnesota. In addition, several cases were seen and diagnosed by physicians without cultural confirmation and other cases have not come to medical attention.

It is significant that both tree packers and tree planters have developed the disease. The moss used in packing is suspect, and this aspect of the outbreak is being studied. Because the trees are widely distributed, a physician faced with a tree planter with lesions that resemble multiple boils should consider *Sporotrichosis Schenckii* as the causative agent in the differential diagnosis.—H. GRANT SKINNER, *State Epidemiologist*, Department of Health and Social Services, Division of Health.

OBSTETRICAL BRIEF

OXYTOCICS: EMPLOYMENT AND SAFEGUARDS

By JOHN R. EVRARD, M.D., Milwaukee, Wisconsin

I. THE USE OF OXYTOCICS
- A. Antepartum
  - (1) Incomplete abortion
  - (2) Hydatid mole
  - (3) Missed abortion
- B. Intrapartum
  - (4) Induction of labor
  - (5) Uterine dysfunction
- C. Postpartum
  - (6) Postpartum hemorrhage due to atony

II. THE INTRAPARTUM USE is somewhat hazardous because of the ever-present danger of ruptured uterus. The contraindications of the use of dilute intravenous oxytocin (Pitocin) during the intrapartum period are:
- A. Polyhydramnios
- B. Multiple pregnancy
- C. Previous scar on uterus
- D. Over para IV

About five years ago, there were approximately 10 maternal deaths each year caused by the injudicious use of oxytocin. These deaths were associated with ruptured uteri and massive hemorrhage. Since that time, the Maternal Mortality Committee has recommended indications, contraindications, and procedures to be followed when oxytocics are used before the completion of the second stage of labor. Cooperation has been good regarding these recommendations and at present the deaths caused by ruptured uteri have been reduced to approximately 3 or 4 per year. The fact that there still are maternal deaths from the misuse of oxytocics reemphasizes the need for repeated discussion of this subject. Recently a new oxytocic called Tocosamine has been introduced into our armamentarium. Until more experience is reached with this particular drug, it should be subject to the same safeguards which we reserve for use of Pitocin.

The Division of Maternal and Child Welfare as well as the Committee on Maternal Mortality again would like to stress:

(1) Careful selection of patients for the use of oxytocics.

(2) The intravenous method is the safest method of using oxytocics.

(3) Constant attendance by the physician is necessary when this drug is used.

Presented at a conference on "Maternal Deaths—What Can We Do About Them?"; St. Catherine's Hospital Kenosha, Jan. 16, 1963; sponsored by the CES Foundation of the State Medical Society.

Reprinted from December 1963 issue of *Wisconsin Medical Journal* at request of Division on Maternal and Child Welfare of Commission on State Departments, State Medical Society of Wisconsin.

BIBLIOGRAPHY ON BIOPHARMACEUTICS

The scope and importance of the science of "biopharmaceutics" are detailed in an extensive bibliography just published by the Pharmaceutical Manufacturers Association. The bibliography contains abstracts and journal references on the influence of pharmaceutical formulation on the therapeutic activity of drugs. Listed are 501 citations. They establish a literature base in a field where, in a broad sense, some ten thousand articles are published annually.

The compilation is an outgrowth of testimony presented before the Monopoly Subcommittee of the Senate Small Business Committee. In these hearings some witnesses suggested that differences in formulation of drug products were negligible or of minor significance in their effect on patients.

"The bibliography lists well-designed clinical studies to show the opposite is true," C. Joseph Stetler, president of the PMA, said.

W. D. James, M.D.

PRESIDENT'S PAGE

Leaves of Change

OCTOBER IN WISCONSIN is always hailed as a time of changing, blazing color. The rapid transformation from green to hues of gold and brown brings visitors from far and near to observe the bright mantle of beauty that hugs the Wisconsin landscape before the winds blow it away.

Such is the pastoral splendor of this October. But, the physician observing the Wisconsin health scene is apt to sense that there is something more than a change of leaves in the swirl of events this fall.

No botanical skill is required to note that "leaves of change" are floating down around the health and medical care system here in Wisconsin as elsewhere in the nation. Under the colors of Public Law 89–749, the Partnership for Health Act suggests dramatic changes in planning for health care and services throughout the state.

A series of meetings started October 1 under the sponsorship of the Bureau for Comprehensive Health Planning of the State of Wisconsin. They will continue on through October offering physicians, other health personnel, voluntary and public health agencies, and all citizens a new look at our health resources, our health problems, and what we can do about them.

This law requires for the first time that non-health-oriented citizens have the majority voice in how the health care of the state is to be organized and delivered. Under Comprehensive Health Planning each area of the state is to be organized into a planning unit. The chief policy body of each planning unit must be composed of a majority of "consumers" who are not directly affiliated with the health professions or health agencies.

Physicians will find it hard to understand how citizens untrained in the health disciplines, no matter how well-intended, can master the intricacies of modern medical care and health services to redesign the system for more efficiency and better health for all. The challenge to these "consumers" is enormous.

Medicine, out of its higher interest in sound health care, cannot step aside saying in effect: "If that's what you want, handle it your own way . . . it's your health and your life." Medicine must offer to the planning majority its own positive, intelligent appraisal of health care shortcomings and strengths in each area. It must exercise its judgment and responsibility as a profession, united and determined to assure the best medical care to all at a reasonable cost. Medicine must be represented well at each of the October planning meetings . . . and the many more that will follow.

Physicians should take no shelter or comfort from the words of the Comprehensive Planning Law which say that nothing in P.L. 89–749 shall "interfere with the private practice of medicine . . ."

It would be a false comfort, at best. It would be a shallow refuge, a running from the physician's highest sense of duty.

This October we cannot escape the "leaves of change." They are upon us. Let's color them bright with medical leadership.

W. D. James MD

the WISCONSIN MEDICAL JOURNAL
Published Monthly

OCTOBER 1968
Vol. 67 No. 10

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

The Ductus Issue

■ IN THE MOUNTAINS of literature dealing with contraception as a means of population control, the primary focus seems to be on the female. The pills, the intra-uterine devices and other attempts to interfere with the processes of ovulation and fertilization suggest that society imposes on the woman the responsibility of birth limitation since nature has imposed on her the function of parturition. Contraceptive methods affecting the female organs are not completely reliable, fraught with possible side effects, and frequently expensive.

Voluntary sterilization of the male, on the other hand, as a means of limiting the size of the family, is safe, quick, effective, relatively inexpensive, and much easier on the woman who has had all the children she wants. Vasectomy is a simple procedure. It can usually be done in the physician's office, using local anesthetic, with little or no loss of time away from work by the patient. It has no effect on the sexual capability of the patient who is free of preexisting psychological difficulties, and its success is usually complete.

The usual religious scruples apply to vasectomy, as they do to other forms of birth control. In addition, the symbolic significance of permanent sterilization bothers some men, although the operation has no bearing on the ability to experience erection and ejaculation. But if a husband and his wife are agreed that they have as large a family as they want or can afford, and have no religious or moral objection to the operation, the man should have no difficulty in obtaining the operation. In fact, it should be suggested to him by his doctor as an alternative to the elaborate precautions his wife must take.

Many doctors, however, hesitate to use or recommend the procedure. Aside from the religious impediment, many doctors are wary of the legality of voluntary sterilization. Only three states, Georgia, North Carolina and Virginia, have laws explicitly legalizing voluntary sterilization. The other 47 states have no statutes on the subject at all, except that it must be limited to "medical necessity" in Connecticut and Utah. This means it is not *illegal* to perform a vasectomy.

As far as civil damages are concerned, the Law Department of the American Medical Association published an

opinion in 1961 that voluntary sterilization procedures present no greater danger of liability than any other medical or surgical procedure alleged to have been negligently performed.

Although he has been urged to do so by the State Medical Society, the Attorney General of Wisconsin has refrained from making any statement as to the status of the vasectomy procedure in Wisconsin. Were he to give a favorable opinion—and there is no reason for him to do otherwise—it would clear the way for a freer use of vasectomy by Wisconsin physicians.

In these days of relative enlightenment about sexual matters, anyone who wants to have his vas deferens divided should encounter no difficulty in obtaining the operation. When the Attorney General clarifies the legal aspects of the procedure, doctors in this state, at least, can have no reluctance to add another successful technique to their armamentarium of reproduction control.—D.N.G.

Educational Opportunity

At no time in medical history has there been such an explosion of scientific knowledge and technology. And never has there been a greater demand for physicians' services.

These factors combine to burden the busy physician in his efforts to keep abreast of the modern developments in medicine.

There is an abundance of fine scientific publications, but many hours of reading would be required to learn what can be gained by attending the Clinical Convention of the American Medical Association. It will be in Miami Beach, Fla. Dec. 1–4.

There will be 125 exhibits there reflecting the latest developments in pharmaceuticals, medical equipment and scientific endeavors.

The Clinical Convention—this will be the 22nd—is one of the best ways of providing continuing education to the busy physician. The scientific exhibits alone are a good postgraduate course in medicine.

And special postgraduate courses will be offered, too, in diabetes, fluid and electrolyte balance and thyroid disease. In addition, there will be about 30 medical motion pictures and scientific television programs will be shown live and in color.

For the physician who likes to discuss the intricacies of his profession, there will be clinical workshops and four breakfast roundtables.

The AMA Clinical Convention is designed primarily for the man in practice. The speakers will read papers that will bring to the practitioner the latest findings of others in his area.

There is an unprecedented emphasis on and need for continuing education. A great manpower shortage has made it mandatory for the physician to expand his knowledge and become more versatile.

The Clinical Convention promises to be a stimulating four days, worthy of the busy physician's time. Every physician is urged to take advantage of this educational opportunity.

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

LETTERS

MEDICAL SCHOOL GRADUATE PLEASED

To SMS:

I have just returned from a vacation graduation trip to New Orleans and Florida. We encountered rain every day for two weeks but had a wonderful time and are now ready to begin another exciting year.

On behalf of my wife and family, I again thank you, the State Medical Society, for the graduation banquet. In addition, I much appreciate the two photographs that were sent me.

Having experienced the thoughtfulness and kindness of the Society as a recent graduate, and being a native of Wisconsin, combines to make me doubly proud of the State Medical Society of Wisconsin.

C. Robert Stanhope, M.D.
Region 5 Vice-president
Student American Medical Association
(Marquette)

NEW SK&F SERVICES CATALOG

To the EDITOR:

Smith Kline & French Laboratories has just released its *SK&F Services Catalog 68/69*. Many of your readers will be interested in this new edition; it offers 58 pages of SK&F services, available to physicians without charge.

Included in the illustrated Catalog are medical films, booklets, periodicals, medical color television, Speakers Bureau, and the "Code 4" cardiopulmonary resuscitation training program.

New to this year's Catalog are the films, "Functional Anatomy of the Human Kidney" and "Vertigo: Differential Diagnosis", which describes the techniques for performing an office examination of the patient with vertigo. Also included are: *Medical Assistant*, a quarterly publication for the physician's office assistant, and Medical Information Service on SK&F products.

The Services Catalog is revised and published yearly by Smith Kline & French as a part of the company's program to provide the medical profession with a wide range of useful services. Your readers may receive a free copy of the *SK&F Services Catalog 68/69* by contacting their SK&F Representative, or by writing to the Services Department E-10, Smith Kline & French Laboratories, 1500 Spring Garden Street, Philadelphia, Pennsylvania 19101.

J. Somers Smith, Jr.
Vice President
Marketing—Pharmaceuticals
Smith Kline & French Laboratories

OSTOMY ASSOCIATION OFFERS HELP

To SMS:

We recently learned of a man in a small Minnesota town who took his own life. His wife writes: "He just couldn't cope with his problem and felt he was a burden to me. I just couldn't reach him. Perhaps if we had known about your organization sooner he could have been saved."

We don't know how many unfortunate ostomates have taken their lives or are living like hermits because they "just can't cope" with their problems. The initial shock of learning that one must undergo such drastic surgery and live with an ostomy for the rest of his life is tremendous but the healthy appearance of one who has experienced the operation has an extremely favorable effect on a prospective ostomate, even after release from the hospital.

Without the uplifting experience of meeting another ostomate many patients may feel they are a burden to their families. Perhaps they are having trouble adjusting to this "strange" new life activity, shying away from social and community obligations. With proper instruction of self care and assistance in rehabilitation problems all this can be eliminated and we are dedicated to this end.

We urge you to remember our name and address with the assurance that we can help anyone who calls upon us that might have problems because of an ostomy. We will refer the patient to the local group (if there is one in your community) or we will send him an information packet with a complimentary copy of the OSTOMY QUARTERLY, as well as giving him free non-medical advice on management problems.

The more new patients we can reach, in cooperation with the medical profession, the more lives we may save, physically and psychologically.

Virginia M. Pearce
Executive Director
United Ostomy Association, Inc.
1111 Wilshire Blvd.
Los Angeles, Calif. 90017

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to:* The Editor, Wisconsin Medical Journal, *Box 1109, Madison, Wisconsin 53701.

WISCONSIN MEDICAL JOURNAL
VOL. 67, NO. 10 OCTOBER 1968

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

WPS Charge Card Corp. Formed; Dr. Mason President

Formal organization of the WPS Charge Card Corporation was completed in Madison Sept. 26 at the State Medical Society of Wisconsin.

The Corporation, wholly owned by Wisconsin Physicians Service–Blue Shield, will arrange post-payment financing of health care expenses. (Details of the plan appeared in the September issue of WMJ at page 437.)

Officers of the new corporation are Dr. Paul B. Mason, Sheboygan, president; E. E. Bryant of the Nelson Muffler Corporation, Stoughton, vice-president; J. R. Possman, Madison, executive vice-president; Attorney R. B. Murphy, Madison, secretary; H. B. Maroney, Madison, assistant secretary; and Dr. John T. Sprague, Madison, treasurer.

Other directors are: Dr. R. E. Callan, Milwaukee; Dr. E. M. Dessloch, Prairie du Chien; Sylvester H. Dretzka, former secretary of the State Board of Pharmacy, Milwaukee; Dr. Milton Finn, Superior; Attorney Charles L. Goldberg, Milwaukee; Dr. D. N. Goldstein, Kenosha; Dr. W. D. James, Oconomowoc; Dr. Robert Krohn, Black River Falls; George Molinaro, president of the American State Bank, Kenosha; Dayton F. Pauls, president of the Citizen's Bank, Sheboygan.

The WPS Charge Card Corporation has authorized capital of $500,000.

AT THE ORGANIZATIONAL MEETING of the WPS Charge Card Corporation Sept. 26 were, in the top photo: John A. Kluwin, legal counsel for the State Medical Society, and H. B. Maroney, assistant secretary of the Society, seated at the far left; and around the table: Sylvester H. Dretzka; Dr. W. D. James, Society president; Dr. John T. Sprague; Dr. D. N. Goldstein; R. B. Murphy (standing); Dr. E. M. Dessloch; C. H. Crownhart, secretary of the Society; J. R. Possman; Dr. R. E. Callan; Charles L. Goldberg, and Dayton F. Pauls. Bottom photo shows Mr. Possman on the left and Doctor Goldstein on the right. Others present were: R. J. Cameron, legal counsel of the Society; D. E. Gill and J. B. White, certified public accountants; R. E. Koenig, E. R. Thayer, and D. C. Reynolds, associate secretaries of the Society; J. P. Lockerbie, sales director of WPS; Mrs. Jean Anderson, personnel director, and Miss Joan Pyre, committee secretary, of the Society.

INACTIVE NURSES

Information about refresher courses for inactive nurses is presented in this issue, at page 61, as a special feature by Signe S. Cooper, RN. The physician's role is explained as well as the future responsibilities in this area.

Statewide Meetings Scheduled for Comprehensive Health Planning

The first of a series of six meetings on areawide comprehensive health planning in Wisconsin started Oct. 1 in Eau Claire, followed by another one in La Crosse Oct. 3.

Sponsor of the meetings, the Bureau of Comprehensive Health Planning, State Division of Health, expects the meetings to stimulate formation of areawide comprehensive health planning agencies.

Other meetings scheduled are as follows:

Oct. 25—Wisconsin Rapids, Wood County Courthouse Auditorium, 400 Market St.

Oct. 29—Fond du Lac, State University Campus Student Center, Johnson St. and Prairie Road

Oct. 31—Rhinelander, South Park School Auditorium, 511 Pelham St.

Nov. 7—Green Bay, Beaumont Inn, Washington at Main

All meetings will be held from 1:00 to 5:00 p.m.

Conferences have not been scheduled at Milwaukee and Madison because these two areas have already received federal grants to develop permanent areawide health planning agencies.

Notice of the meetings was sent to major health and health related organizations and to consumer organizations. Widespread representation for the establishment of the areawide planning units is sought. Dr. George H. Handy, director of the state health planning bureau, said that representatives from all interested groups are welcome.

Information relating to the "Partnership for Health" program, launched nationwide as the result of recent federal legislation, is being presented at the meetings by Dr. Handy and Vincent F. Otis, deputy director of the state health planning bureau. The information centers on the role of an areawide health planning agency, its organizations and functions.

An areawide agency must provide for representation of consumer groups and the major public and voluntary organizations and institutions concerned with physical, mental and environmental health services, facilities and manpower. The majority of members on the board of directors or advisory councils must be consumers of health services broadly reflecting geographic, socio–economic, and ethnic groups in the area.

The remainder of the representation are persons in health and health-related activities such as doctors, nurses, therapists, or public health professionals.

A limited amount of federal grant money is available on a 50–50 matching basis for the development of comprehensive areawide health planning agencies.

Simple Obesity Not Simple AMA Warns

Physicians, as well as the public, are being alerted to the dangers involved in the use of potentially dangerous drugs in the treatment of simple obesity.

As part of a nationwide campaign, the American Medical Association is appealing to doctors of medicine to demonstrate their competence in protecting the public against the hazards in weight reduction programs which involve the use of drugs.

The AMA points out the widespread publicity given to a certain minority of physicians who limit their practice to the treatment of obesity. It warns that: "the use of digitalis, prolonged diuretic administration, and toxic doses of thyroid, as well as other potentially dangerous therapeutic modalities, have no rational basis in the treatment of obesity alone."

"The dispensing of such potent drugs for uncomplicated obesity is to be condemned," the AMA said.

Physicians are urged to remember that when obese patients weary of the prolonged effort necessary to readjust to a sensible dietary way of life, they become easy marks for those who promote allegedly quick, simple weight reduction.

WPS TO HOST MIDWEST FINANCE SEMINAR

WPS–Blue Shield will host a Midwest Finance Seminar Oct. 30 and Nov. 1 at Hoffman House East in Madison. Representatives from Blue Shield and Blue Cross plans in the states of Iowa, Minnesota, Michigan, Missouri, Illinois, Indiana, Ohio, Nebraska, Wisconsin, and possibly others will discuss such topics as statistical sampling techniques, coordination of benefits, computer cost-accounting, planning and problem solving techniques, budgeting, financial statement presentations, utilization audit and review. Hopefully, a national leader in cost sharing as it relates to Medicare contracts will be on the program. Expected also are national officers of BC and BS in the area of finance.

President James Addresses Medical Records Librarians

Dr. William D. James of Oconomowoc, president of the State Medical Society, addressed the 33rd session of the Wisconsin Medical Record Librarians at the Pfister Hotel in Milwaukee Sept. 19. His subject was "The Value of the Medical Record Librarian to the Practicing Physician." As president of the Society, Doctor James is available for speaking engagements upon 30 days notice to the State Medical Society's Speakers Bureau.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio–economic interest to physicians and others.

Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1968 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thayer, Director of Socio–Economic Medicine.

SMS Hot Line

THE TREMENDOUS RESPONSE to the 6th Annual Wisconsin Work Week of Health Oct. 1-4 (total attendance 3,045) points to a great demand by educators, parents, and teenagers for current health information from the most reliable source—the physician.

TYPICAL COMMENTS FROM STUDENTS: "A-1" "the students weren't preached at" . . . "keep up the good work, you've got a good thing going" . . . . "The speakers didn't act like know-it-alls" . . . "could it be possible for county medical societies to plan these programs so they could get out in the state farther" . . . "I'd like to see more discussion of sex, and more food for lunch" . . . "not enough depth . . . need more time for discussion" . . . "should be continued so the teenagers won't be ashamed to consult with their parents.

PRESS COVERAGE of the Work Week was outstanding: Madison Capital Times, Wisconsin State Journal, Milwaukee Journal, Milwaukee Sentinel, Green Bay Press-Gazette, Minneapolis Tribune sent reporters. Film coverage by WISC-TV, WITI-TV, WLUK-TV, WKOW-TV, WHA-TV . . . radio by all Madison stations. National medical papers requested photos and stories, sent photographers. Seventeen Magazine requested photos and lengthy stories plus video tapes for future story.

MORE THAN 150 HIGH SCHOOLS sent students, most with instructions to report back to high school assembly meetings.

MANY HIGH SCHOOLS are requesting copies of tape recordings and TV-kinescopes for use in their assemblies and classes. WPS-Blue Shield making grant to WHA-TV to produce recordings for widespread use by schools and other groups.

ELSEWHERE ON THE STATE SCENE . . . First two Comprehensive Health Planning meetings have been held . . . the Eau Claire session attracted 140 persons including 12 MDs, the La Crosse meeting drew 130 representatives and 11 MDs. Following each meeting, physicians gathered for MD discussion of their role, latter meeting sponsored by State Medical Society.

WAGP, at its annual meeting Sept. 25-26 in Milwaukee, urged the state legislature to subsidize Marquette medical school and further asked the legislature to study a way to induce young doctors to stay in Wisconsin and practice in areas lacking physicians.

WPS IS INCREASING PREMIUM RATE on Medicare-PLUS $15,000 supplementary contracts to cope with high utilization of benefits. Premium was $7.95 per person per month, will go to $9.50 as of Nov. 1 as renewals come up. This is the first change of rate on this plan since 1966 when it began.

3000 Teenagers "Invade" Society Headquarters "Capture" Health Tips at Work Week of Health

"Cool" was the key word for over 3,000 high school teenagers, their chaperons, and other health-minded persons during the sixth annual Wisconsin Work Week of Health Oct. 1–4 at State Medical Society headquarters in Madison.

It was "cool" because the speakers enthralled their audience with frank, simple, constructive statements that left the decisions and discretions to the youth.

From health in underdeveloped countries abroad and in the ghettos at home, to marijuana smoking, dieting, good hygiene, use of LSD, and sex life, the speakers dealt the cards but left the playing to their audience.

It was "cool" because 3,000 youth gathered for intensive education which they conscientiously accepted with seriousness. The exceptionally well-behaved group exemplified the general student body from all parts of the State including the northern city of Ashland.

This year's event was so popular that on two of the four days, groups were sent to the Holiday Inn and to the VFW building where speakers made a second presentation. There were 600 scattered throughout the Society building daily, many watching on closed circuit television which had been provided by WHA-TV, the University of Wisconsin educational station, through a grant of Wisconsin Physicians Service–Blue Shield.

"Youth on a Four-Day Trip" is the first such program ever presented in the United States by a medical society. It will undoubtedly provide background information for other similar programs.

OFFICIAL GREETERS for the first day's program of the Work Week of Health were Society president Dr. W. D. James of Oconomowoc; Angus B. Rothwell of Madison (center), executive director of the Coordinating Council for Higher Education; and Greg Laska of Wausau (right), president of the Wisconsin Youth Committee that helped plan the program. Doctor James and Dr. R. E. Callan of Milwaukee, Society president-elect, were hosts for the four days.

THE WOMAN'S AUXILIARY to the State Medical Society was instrumental in the promotion and publicity as well as being official hostesses.

WORK WEEK PROGRAM VIDEO–AUDIO TAPED FOR EDUCATIONAL USES

WHA–TV, under a grant by WPS–Blue Shield, video-taped eight of the 16 topics presented at the Wisconsin Work Week of Health. These will be aired on the state educational network. Further showings will be made by other stations as public service features.

The same eight topics are on kinescopes and available to high schools, civic clubs, and other such organizations.

All 16 topics were audio-taped and are available on loan for teaching purposes.

Contact the State Medical Society's Public Information Department, Box 1109, Madison, Wis. 53701, or telephone (608) 257–6781.

'FOUR-DAY TRIP'

Emphasis on Youth, Health

The challenge of putting together a sparkling, provocative, relevant program is an eternally formidable one.

Especially when the audience is to be full of teenagers.

Above all when the planning has to involve 48 different organizations!

But that's just what the State Medical Society of Wisconsin and its 47 co-sponsors have achieved in the 1968 Work Week of Health which opens Tuesday at the Medical Society bldg. here.

The theme is "Youth on a Four-Day Trip." Daily topics include "Health Horizons Unlimited," "The Care-Free Years," "How to Turn Health Off (and On);" and "Hippie Health."

Subjects assigned authoritative speakers and panels include—among many others—"Should You Keep Off (or On) the Grass?" (health aspects of marijuana); "Sex and the Teenager;" "Why Students Crack Up;" "Sports on Trial;" and discussions of teenage driving, cosmetics and good looks, LSD, drinking, health hazards of hippie living.

It sounds like a great four days.

Possibly one of the secrets of setting up such an attractive and stimulating program lies in the planning: the sessions were planned with as well as for Wisconsin youth.

Other conference chairmen please note.

—Reprinted with permission from WISCONSIN STATE JOURNAL, Sept. 30, 1968

BEAUTIFUL FALL WEATHER prevailed for the four-day Work Week of Health and many enjoyed their free box lunches on the Society's front lawn. Others strolled on the Society pier to observe the colorful foliage and Madison's skyline across Lake Monona.

AMONG THE 30 some speakers were Dr. Harvey L. P. Resnik (upper right), associate professor of psychiatry, State University of New York, Buffalo, who spoke on Sex and the Teenager; Dr. Frederick Bunkfeldt, Jr. of Milwaukee (lower left) who explained emergency care procedures; and Dr. William B. Walsh of Washington, D.C. (lower right), director of Project Hope, which also was his topic.

TWO OF THE PANELISTS participating in "An Interview with the Health Experts" were Dr. R. E. Callan of Milwaukee (left) and Edward J. Logan, president of the Wisconsin Hospital Association.

Workmen's Compensation Insurance Coverage for Employes Due Jan. 1

Physicians Alert! Be sure to get Workmen's Compensation insurance coverage for your employes before Jan. 1, 1969.

Every physician with a payroll of $500 or more in the third or fourth calendar quarter of 1968 must have a Workmen's Compensation insurance policy in effect by Jan. 1. This is the requirement of Workmen's Compensation amendments passed by the 1967 session of the Wisconsin Legislature.

Even though you have less than three employes, you must have the coverage in effect if you pay wages of $500 or more in any calendar quarter (this works out to $166.67 a month).

Workmen's Compensation insurance may be obtained from any company authorized to write such business in Wisconsin.

Serious penalties exist for failure to have insurance coverage. First, such failure is a misdemeanor and subject to fine of from $10 to $100 for each day of such illegal operation.

Second, the employer is personally responsible if one of the employes is injured while he is subject to coverage and is uninsured. Negligence by the employe is not a defense, and it need not be shown that the injury was caused by negligence of the employer.

A physician paying such wages need only obtain an insurance policy for Workmen's Compensation to comply with the law. The state W. C. office is automatically notified of the issuance of the policy.

PHYSICIAN WANTED!

The Division of Vocational Rehabilitation of the State Department of Health and Social Services is interested in a physician who would have time to act as a Medical Consultant to the Disability Determination Section. Anyone interested may contact Mr. Al Meier, Senior Supervisor, Division of Vocational Rehabilitation, 137 E. Wilson St., Madison, Wis. 53703; tel. (608) 266-1565.

DR. HOUSNER NAMED ADVISOR FOR HOSPITAL CONSTRUCTION

Dr. Richard E. Housner, Richland Center, will represent the medical profession on the State Council on Hospital Construction as a result of his appointment to a three-year term on that body.

R. E. Housner, MD

The Council is part of the Division of Health of the Wisconsin Department of Health and Social Services.

Doctor Housner will assist in the annual review of the state hospital plan which is used as a guide in allocation of federal grants for the construction of hospitals in Wisconsin.

FAMILY HEALTH WEEK NOVEMBER 17–23

Congress approved legislation designating Nov. 17–23 as "National Family Health Week." The legislation termed the week "as a means of focusing national attention during the year upon the accomplishments of the American health care system and the central role played by the family physician in the maintenance of superior medical care for Americans of all ages and from all walks of life."

Senator Ernest Gruening of Alaska and Representative Tim Lee Carter of Kentucky introduced the legislation at the request of The American Academy of General Practice. Both men are physicians and Doctor Carter is a member of AAGP.

New Health Exam Form for State Universities

A new standard health form will be used for student entrance physical examinations at the nine Wisconsin State Universities, the WSU system office in Madison reports.

Since Oct. 1, the new form has been distributed to students making application to enter next year as freshmen. Supplies of the new form are also available to physicians.

The new form appearing on the next two pages, replaces the nine individual health forms previously used. It was developed by physicians who direct student health services at each university and by the WSU system office.

About 22,000 entering students will use the form this year. The standardized design is intended as a convenience to physicians and as an aid to registrars and health services at the universities.

Designed to be read by data processing machines, the new form will enable the universities to quickly identify students with unusual health problems and those requiring limited physical education programs. Computers will indicate which students have not completed various tests and immunizations.

Without identifying individual students, data obtained from the health forms at all State Universities will be analyzed in studies of general health conditions and patterns by age and sex.

Students making application for admission will receive a health form from the university. However, since the form is to be machine read, it must not be damaged or defaced in any way. It must be completed with lead pencil, and information must be confined to the area inside the horizontal lines on the right margin.

A supply of sample forms for office use will be made available to physicians who complete and return the attached card, at page 546.

DR. HILL APPOINTED TO NURSING HOME COUNCIL

Dr. Nels A. Hill, Madison, past president of the State Medical Society has been appointed to membership on the Council on Nursing Homes of the Division of Health, Wisconsin Department of Health and Social Services. He will serve a three-year term ending July 1, 1971, as a representative of the medical profession. The Council advises the Division of Health regarding establishment and review of minimum standards and rules and regulations governing the licensing and operation of nursing homes in Wisconsin.

Nels A. Hill, MD

SOCIAL SECURITY BENEFITS

Some $479 million in social security benefits are being paid to 466,000 students age 18–22—an amount greater than the scholarships at all colleges and universities in the U.S.

Watch Out for That "Flu Bug"!

The occurrence of a sizable outbreak of influenza in Hong Kong recently, due to a considerably altered strain A_2 (Asian) influenza virus, has led to the prediction that the United States may experience extensive occurrence of influenza during the coming winter, according to an announcement by the AMA's Council on Environmental and Public Health.

Currently available bivalent and polyvalent vaccines may provide only limited protection against the new strain, designated as A_2/Hong Kong/68. The Surgeon General of the Public Health Service has urged licensed vaccine manufacturers to begin development and production of a monovalent vaccine containing A_2/Hong Kong/68 as soon as possible. It may take from three to six months to produce any substantial amount of the new vaccine.

Meanwhile, currently available vaccine should be administered to those groups at greatest risk of mortality or of serious complications of influenza, and these high-risk groups should be given the highest priority for receiving the new monovalent vaccine when it becomes available.

High-risk groups include persons over 45 years of age and even more notably for those over 65, and those individuals with chronic illnesses as defined below:

(1) Patients with rheumatic heart disease, especially with mitral stenosis;

(2) Patients with such cardiovascular disorders or arteriosclerotic heart disease and hypertension, especially showing evidence of frank or incipient cardiac insufficiency;

(3) Patients with chronic bronchopulmonary diseases such as asthma, chronic bronchitis, cystic fibrosis, bronchiectasis, pulmonary fibrosis, pulmonary emphysema, or pulmonary tuberculosis.

The AMA's Council on Environmental and Public Health urges component societies and individual practitioners to inform themselves as to the Public Health Service's recommendations for the use of influenza vaccines, and to see that the high-risk groups receive first consideration for vaccination. The Council also recommends that individual practitioners report increased incidence of flu-like respiratory disorders promptly to local or state Public Health Agencies for early identification of the causative virus.

TO THE STUDENT: Please answer all questions. Consult your parents for accurate and complete answers to medical history questions. The information will be treated confidentially; it will not affect your college standing.

IMPORTANT: Use ordinary black lead pencil (not ink or ball point pen). Make marks heavy and dark, fill between horizontal lines, do not use X's. Erase completely any marks you wish to change.

Name _____ (Last Name First)

Home Address _____

_____ (Zip Code)

Student Social Security

Parent or Guardian _____

Home Address _____ (Street, City, State) (Zip Code)

Home Phone: Area Code _____ Number _____

Birth Date: _____ Month / Day / Year

Sex: ----- Male ----- Female

Age Grouping

----- 17 or under ----- 18-20 ----- 21-25 ----- 26-30 ----- 31 & Over

Current Marital Status

----- Single ----- Married ----- Widowed ----- Divorced ----- Separated

MOST OF YOUR LIFE

Area of Residence ----- U.S. & Can. ----- Lat. Am. ----- Europe ----- Asia ----- Other

Home Community Size — Population in Thousands

----- Under 5 ----- Under 10 ----- 10-50 ----- 50-250 ----- Over 250

Religion ----- Catholic ----- Jewish ----- Protestant ----- Chris. Scien. ----- Other

If you have a personal physician how many times have you consulted him in the past year?

----- None ----- 1 ----- 2 ----- 3 ----- More

Is he from your home area? Yes ----- No -----

Is he an ----- MD ----- Osteopath Other _____ (Specify)

If you become ill at the University, do you anticipate using:

Student Health Service ----- or Private Physician -----

Father Living ----- Deceased -----

Mother Living ----- Deceased -----

Cause of death if known, and age at death _____

Have you been enrolled in this University before? Yes ----- No -----

If you do not have health insurance, do you plan to obtain some? Yes ----- No -----

FAMILY

Number of living children who are your

full brothers: ----- 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 or more

full sisters: ----- 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 or more

Among these, is there a Twin Pair ----- Triplet -----

Are you a member of a living Twin Pair ----- Triplet -----

Among your living full brothers & sisters, are you the

----- Oldest ----- 2nd ----- 3rd ----- 4th ----- 5th ----- 6th ----- 7th ----- 8th ----- 9th ----- 10th or more

Have any of your brothers or sisters attended this University? Yes ----- No -----

HISTORY

Among your blood relatives, is there any history of or present illness in the following? For each yes, specify illness and relationship.

	Yes	No
Allergy	-----	-----
Heart Disease	-----	-----
Tuberculosis	-----	-----
Recurrent Severe Headaches	-----	-----
Cancer	-----	-----
Diabetes	-----	-----
Convulsions or Blackouts	-----	-----
Emotional Trouble	-----	-----

H97361

WISCONSIN STATE UNIVERSITI
ENTRANCE PHYSICAL EXAMINAT

DO NOT WRITE IN THIS SPACE

Respond to all columns shown at right and for each yes explain briefly below:

STUDENT PERSONAL H

Do you have or have you ever had?

Diabetes

Convulsions or Blackouts

Mental or Emotional Illness

Other Serious Illness

Un

Hay Fever

Eczema

Asthma

Rheumatic Fever

Heart Disease

Tuberculosis

Recurrent Severe Headaches

Appendectomy

Tonsillectomy

ARE YOU ALLERGIC TO:

Penicillin

Horse Serum

_____ Other Drugs (Name)

ANY UNUSUAL PROBLEMS WIT

Head, Eyes, Ears, Nose or Throat

Chest

Heart

Stomach or Intestines

Kidney or Bladder

Muscles or Bones

Menstrual Difficulties

Hernia

Fractures

Other Significant Operations, Accidents Illnesses (Explain)

Have you ever had X-ray Therapy If yes, to what part of the body? Yes

----- Head or Neck

How many cigarettes per day do yo regularly?

----- None ----- Less than 1 2 pack

Total number of years you have sm cigarettes regularly

----- None ----- 1-2 ----- 3-4

WISCONSIN STATE UNIVERSITIES
ENTRANCE PHYSICAL EXAMINATION

PHYSICIAN: Please mail completed form to:

(Student: Fill in name and address of College or University you will attend)

PLEASE USE PENCIL ONLY

IMPORTANT

Use ordinary black lead pencil (Not ink or ball point pen) for the horizontal marks, do not use X's.

Be sure to make the marks heavy.

STUDENT SOCIAL SECURITY

CODE A B C D / 1 2 3 4

Date

MD's Initials

DO NOT WRITE IN THIS SPACE

TO THE DOCTOR: Please review the personal and family history and record the physical examination.

Smallpox vaccination, polio, and tetanus toxoid immunization are strongly recommended. Verification of freedom within the last year from active tuberculosis is required (intermediate strength PPD is recommended for the skin test.) Adaptive physical education is available for partially disabled students. Documentation and description of the disability is most helpful to us.

MEDICAL EXAMINATION

WEIGHT — Overweight — Underweight — Normal

WEIGHT _____ Lbs. HEIGHT _____ Ft. _____ In.

HEMOGLOBIN _____ Normal — Abnormal

HEMATOCRIT _____ Normal — Abnormal

BLOOD PRESSURE _____ / _____ Normal — Abnormal

VDRL — Neg. — Pos. — Not Done

URINALYSIS — Neg. — Sugar

ABNORMALITIES — Alb. — Micro.

TB X-RAY (Within last year) — Neg. — Pos.

TB SKIN TEST — Neg. — Pos. — Not Done

SMALLPOX VACCINATION Done at this time? — Yes — No

DO ABNORMALITIES APPEAR	Yes	No
Eyes (Refractive)		
Eyes (Other)		
Ears, Nose, Throat		
Respiratory		
Cardio-Vascular		
Gastro-Intestinal		
Genito-Urinary		
Muscular-Skeletal		
Neuro-Psychiatric		
Metaholic		
Is the student on medication?		

Has the student been immunized for:	Yes	No	If yes, Year Given
Smallpox			
Polio (Injected)			
Polio (Oral)			
Tetanus			
Diphtheria			

PHYSICIAN

Have you known this student as a patient?

More than 1 Yr. — Less than 1 yr. — Is this his 1st visit?

Recommendations for Physical Education, Intramurals, ROTC

Any Activity — Any Except Swimming — Limited (Explain Below)

Do you have any recommendations regarding the care of this studen while attending the University?

If yes, explain below — Yes — No

NAME

SIGNATURE OF PHYSICIAN

X _____

Print Name _____

ADDRESS

Number & Street _____

City _____ State _____ Zip Code _____

Telephone: (Area Code) _____ Number _____

Date _____

Use This Column to Explain Fully Any Positive Findings, Abnormalities, Recommendations

the wisconsin medical journal

VOLUME 67/NUMBER 11 NOVEMBER 1968

Ophthalmopathy with Hypothyroidism

By GEORGE W. DEAN, M.D., Milwaukee, Wisconsin

■ OVER A PERIOD of years the author has known of several patients with classical ophthalmopathy who were not benefited by thyroidectomy or other forms of suppressive therapy. It has been the frustrating experience of many physicians when a patient with Graves' disease did not obtain relief from the ophthalmopathy after thyroidectomy. The disappointment of the physician was matched by the dismay of the patient.

With the advent of more sophisticated tests for thyroid function it became obvious that ophthalmopathy and its attendant signs and symptoms may occur in the euthyroid patient. Recently, reports have entered the literature of ophthalmopathy occurring in the hypothyroid state. The case presented below is an example of the latter; while not rare, it occurs infrequently enough to warrant reporting. Fox and Schwartz[1] reported one patient with primary hypothyroidism in whom there also occurred ophthalmopathy. They stated that at least 46 cases had been previously reported.

Case Report

This 40-year-old married woman was seen for the first time in May 1959 because of bronchial asthma and chronic allergic rhinitis. The family history revealed that her father underwent thyroid surgery on two separate occasions because of "exophthalmic goiter" but there was no relief of his exophthalmos. Her mother also had a thyroidectomy but apparently did not have exophthalmos.

In July 1959 another physician sent her to the hospital because of fever of undetermined origin. Interestingly enough, the intern who saw her on this occasion felt that she had a "thyroid condition" but the attending physician did not. Following allergy testing a program of desensitization to pollens, molds, animal danders, feathers, and house dust was initiated. For symptomatic relief a bronchodilator–iodine mixture was prescribed but this was not taken regularly since overuse seemed to cause acne. When we first saw her, her erythrocyte sedimentation rate was 77 mm/hr and about six months later it was 2 mm (Westergren).

In July 1962, the patient complained of excessive fatigue, drowsiness, dryness of her skin, and puffiness of her face. Her appearance at that time was typical of hypothyroidism and the basal metabolic rate (BMR) was —30%. She was treated with dessicated thyroid and a prompt elevation of her BMR was noted. In March 1963, the patient and her friends began to note increasing prominence of her eyes. At first this did not concern her because her eyes had always been more or less prominent. As the exophthalmos persisted she became worried and visited her family physician. He felt that perhaps she was getting too much thyroid and advised that it be stopped. When the thyroid was discontinued, all of her symptoms of hypothyroidism recurred but the exophthalmos did not recede.

When examined at this time, there was a moderate exophthalmos (right 27 mm, left 26 mm), moderate edema of the upper and lower eyelids, mild chemosis, moderate lid lag, and a definite paresis on upward gaze. The thyroid was slightly and diffusely enlarged with no nodules. The patient was seen by a consultant who felt that she had Graves' disease with hypothyroidism. He found the level of butanol-extractable iodine serum low (normal 3.5 to 6.5 mcg/100 ml), and he recommended that thyroid be continued and iodine avoided.

On January 9, 1964, because of a persistence of the ophthalmopathy, prednisone was prescribed and has been continued up to the present time, the recent dose averaging 7.5 mg per day. With prednisone there was an immediate improvement particularly

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in the edema of the eyelids but the exophthalmos on repeated examinations measured about the same. When an attempt was made to discontinue the steroid, edema of the eyelids promptly recurred. She has continued taking thyroid substances, most recently sodium levothyroxine (Synthroid), 0.1 mg three times daily.

On this program her allergy symptoms have been minimal, possibly as a result of the steroid. She has had several other unrelated illnesses and surgery twice without complications. Over a period of time there has been a gradual increase in the blood pressure to mildly elevated levels promptly controlled by chlorothiazide. From time to time purpuric spots have appeared on her skin probably associated with steroid therapy. Repeated urinalyses and blood chemistry studies have shown no tendency to diabetes. She has been seen on a number of occasions by an ophthalmologist who concurred with the treatment being given. At the present time the patient feels well and is employed in addition to taking care of her household. She has made an excellent adjustment to her various conditions and has accepted the fact that she must continue with the medications.

Discussion

Ophthalmopathy may be one of two types: that associated with hyperthyroidism or that with the euthyroid or hypothyroid state. It has been known for many years that thyroid activity is under control of the thyroid stimulating hormone (TSH) of the pituitary gland. Subsequently a new hormone of the pituitary, exophthalmos producing hormone (ESH), and more recently, long-acting thyroid stimulator—a 7-S gg (LATS), have been demonstrated. Opinions vary as to the significance of LATS and thyroid disease. Lipman *et al*[2] point out that LATS occurred most frequently (89%) in patients with three manifestations of Graves' disease, namely hyperthyroidism, ophthalmopathy, and pretibial myxedema; in 63% with two manifestations and in 47% of those with only one manifestation. The titre of LATS appeared to be highest in active Graves' disease and tends to fall with the passage of time irrespective of treatment given.

In the report of Fox and Schwartz[1] it was pointed out that LATS was present in the serum of their patients who had ophthalmopathy with hypothyroidism. It would appear that the presence or absence of LATS in the serum is of little or no diagnostic value. Pequegnat *et al*[3] of the Mayo Clinic concluded that the ophthalmopathy and the LATS of Graves' disease may arise as the result of the same stimulus but not be causally related to each other. Lipman *et al*[2] felt that the serial LATS determination may be of aid in the prognosis since the level of LATS drops as the ophthalmopathy improves. Pequegnat *et al*[3] pointed out that large doses of thyroid substances may cause typical hyperthyroidism but not ophthalmopathy and pretibial edema. This fact is important in the patient under discussion since her ophthalmopathy began while she was taking thyroid for hypothyroidism.

Haddad[4] reported one patient with ophthalmopathy who originally was hypothyroid but subsequently became hyperthyroid. We have been on the alert for this in our patient since she apparently has considerable thyroid tissue. Pinchera *et al*[5] studied six cases of Graves' ophthalmopathy who were either euthyroid or hypothyroid and found that LATS was absent in all.

The determination of LATS in the serum is a test which is not widely available and is not done in the local area. Furthermore it was not available at the onset of this individual's ophthalmopathy and we do not feel that it would be of any value from a diagnostic or prognostic standpoint at this time.

The progress of ophthalmopathy associated with myxedema is uncertain since the ophthalmopathy does not depend on or seem to be associated with the thyroid status. Hence the ophthalmopathy must be treated as an independent condition. The treatment of ophthalmopathy not associated with hyperthyroidism is directed at the eye condition primarily and can be divided into three aspects: (1) the pituitary, (2) anti-inflammatory agents, and (3) local measures to prevent injury to the eye. Among the pituitary factors outlined by Haddad,[4] he listed thyroid hormone substitutes as suppressive treatment. This modality is being used in our patient and it also has the effect of relieving her myxedema. Haddad felt that pituitary ablation and measures such as the use of thyroid analogues and TSH inhibitors were of little value.

The use of steroid hormones as an anti-inflammatory agent has been quite successful in our patient in relieving the edema of the eyelids, lessening the retraction of the lids, and relieving the ocular symptoms although the exophthalmos has shown very little tendency to regress. Similar results were obtained by Brown *et al.*[6] While the use of surgical decompression of the orbit was considered early in the course of this patient's illness, her response to steroid ther-

apy has apparently eliminated the need for surgery. Early in the course of her condition she complained quite bitterly of conjunctival irritation and soothing eye drops were prescribed. However when steroid therapy was commenced, the need for local treatment lessened. Thiazide diuretics have been used for the control of her hypertension and possibly may have some beneficial effect.

Summary

Whereas infiltrative ophthalmopathy usually occurs in association with hyperthyroidism, it also can occur in the euthyroid and occasionally in the hypothyroid individual. The patient reported here developed ophthalmopathy while she was being treated for primary hypothyroidism of undetermined etiology. Methods of treatment have been described and this patient appears to be responding in a satisfactory manner.

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COMPLICATIONS OF RADICAL NECK DISSECTION

FRANCIS W. PARNELL, MD, Div of Otolaryngology, Dept of Surg, Univ of Wisconsin Medical Center, Madison, Wis: *Arch Otolaryn* 88:180–183 (Aug) 1968

The most common postoperative complications following total laryngectomy and radical neck dissection for advanced carcinoma of the larynx include postoperative edema, delay of wound healing, necrosis of skin flaps, wound infection, fistulae formation, and rupture and hemorrhage of the carotid artery. The prevention and management of each of these complications are discussed.

This review summarizes the relative incidence of the complications following either combined radiotherapy and surgery, or surgery alone in the treatment of 24 successive cases of advanced carcinoma of the larynx during the past 18 months at the University of Wisconsin Medical Center.

No significant statistics can be obtained from this series as yet regarding survival rates. However, it is concluded that preoperative radiotherapy in the dose of 5,000 rads is associated with an increased incidence of postoperative complications compared to those obtained with radical surgery alone in the treatment of advanced carcinoma of the larynx.

PENALTIES OF PROGRESS: DRUG-INDUCED HEMATOLOGIC DISEASE

ANTHONY V. PISCIOTTA, MD, Marquette School of Medicine, Milwaukee, Wis.: *Postgrad Med* 43:213–219 (May) 1968

An unexpected drug reaction may occur whenever a drug deleterious to cell function (the toxic factor) comes in contact with a patient who responds in a unique or unpredicted fashion (the host factor). Two mechanisms have been implicated: immunologic and toxic, or biochemical. In any case, a drug reaction may occur only if the host is abnormal in some respect. Amidophyrine-induced agranulocytosis and quinidine-induced thrombocytopenic purpura are examples of immunologically mediated blood dyscrasias and represent an abnormal antibody to drug, resulting in peripheral destruction of cells. Hemolytic anemia, based on a genetically conditioned enzyme deficiency may occur whenever primaquine is given to patients whose red cells lack glucose-6-phosphate dehydrogenase. The phenothiazines may produce decompensated bone marrow depression with agranulocytosis in patients whose marrow proliferative potential is low to begin with. These patients characteristically have limited DNA synthesis in their marrow cells which is further adversely affected by certain phenothiazines. Chloramphenicol is a major problem, because the aplastic anemia it rarely produces is fatal and incapacitating. In addition, chloramphenicol has been implicated in a widespread, but fortunately temporary marrow depression, if used in large doses. The best treatment for drug toxicity is prevention; the physician must know which drugs produce hematopoietic damage and if possible, avoid or limit their use.

ANTILYMPHOCYTE SERUM

The results of animal experiments conducted by a London immunologist suggest that antilymphocyte serum (ALS) may be of value in treating immune disorders in man; ALS is currently employed clinically only for suppression of the body's rejection mechanism following homografts. A series of studies is being planned to evaluate ALS in treating post-vaccinal encephalomyelitis, systemic lupus erythematosus, dermatomyositis, and other immune disorders.—From *International Medical Digest*, July 1968

WERNER'S SYNDROME

By PALMER G. TIBBETTS, M.D., HAROLD D. ROSE, M.D.
and DAVID W. KERSTING, M.D., Milwaukee, Wisconsin

■ WERNER'S SYNDROME, also known as Progeria of Adulthood because of the premature senile changes of the lens, skin, vascular and osseous systems, is a clinical syndrome with the following distinguishing characteristics: (1) a short, stocky trunk, combined with slender extremities, bird-like facies and a beak nose; (2) premature poliosis and baldness, atrophic skin of the extremities, premature arteriosclerosis and osteoporosis; (3) premature cataracts in the third and fourth decade; (4) scleroderma-like changes, with taut skin over atrophic subcutaneous tissues of the face and extremities; (5) endocrine and metabolic defects usually seen as hypogonadism and diabetes; (6) history of consanguinity and familial incidence; (7) thin, high-pitched voice; and (8) circumscribed hyperkeratoses and callosities.

In his paper entitled "Cataracts in Combination with Scleroderma" in 1904, Otto Werner[1] described four siblings with a clinical syndrome which he believed was related closely to the syndrome which Rothmund[2] had described in 1868. The two syndromes were generally considered identical until 1934 when Oppenheimer[3] first described the condition for the American literature and coined the eponym "Werner's Syndrome" emphasizing the difference between this entity and Rothmund's patients with cataracts and telangectasia. In 1945 Thannhauser,[4] in a classic review of the 26 previously reported cases, further clarified the distinguishing features of Werner's syndrome. He clearly demonstrated that although the lesions were clinically similar to scleroderma, there were essential differences in the symptoms and the course, and that the histologic changes in scleroderma were entirely distinct from those in Werner's syndrome. Epstein *et al*[5] recently reviewed 140 cases of Werner's syndrome which have been reported in the world literature. On a statistical basis, they estimated that at the present time there are a significant number of unrecognized instances of Werner's syndrome in the United States.

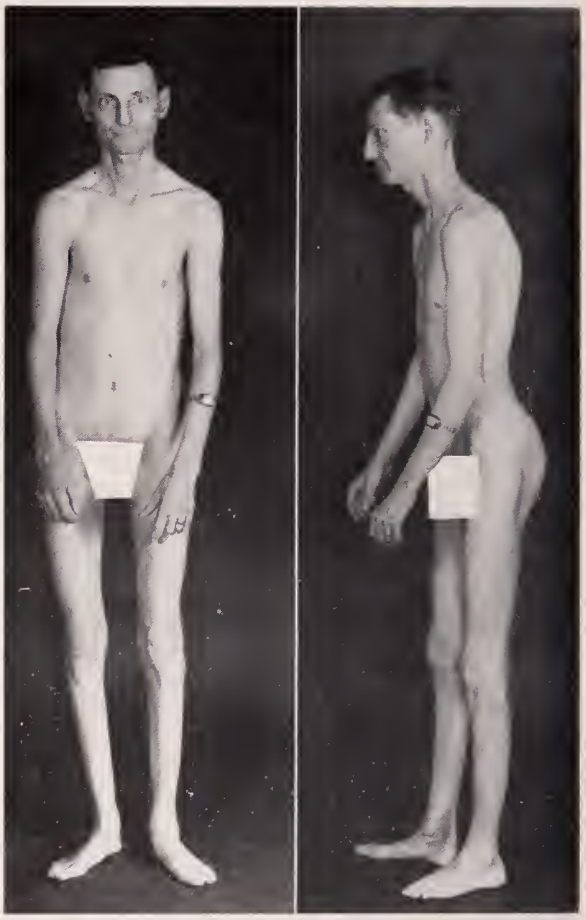

Fig. 1A—Werner's syndrome: Typical body habitus at age 34 years.

The purpose of this report is to record observations of a patient with Werner's syndrome over a period of 10 years, to clarify the differential diagnosis, to review theories of its etiology, and to emphasize the

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Fig. 1B—Tightness of skin of lower extremities with bilateral ulcerations.

disabling effect on the patient's physical functions caused by the progressive inexorable tightening of the skin.

Case Report

The patient is a white man who was 34 years of age when he first sought treatment of bilateral chronic medial malleolar ulcers. He related the onset of the ulcers, one year previously, to minimal traumatic abrasion of the ankles. An attempt at skin grafting had failed, and various medications including compresses and ointments had been used in treating the ulcers. Medical history included only the diagnosis of pes planus at age 20. He denied Raynaud's phenomenon and dysphagia. He had had a lyric soprano voice since childhood. His average weight was 130 lb, with a range from 90 to 130 lb since age 18.

His father and mother were of German and Hungarian descent, of heavier stature, and without early graying, balding, or similar symptoms. His father had diabetes. Eleven siblings were surveyed by questionnaire and all reported they were well with no similar symptoms. Only history of consanguinity was that his maternal grandmother was an aunt to the paternal grandmother.

Physical examination revealed a markedly underweight white man with bird-like facial features and beak-like nose (Fig 1A). His blood pressure was 122/85 mm Hg; external genitalia were small but normally developed. There were 2 cm bilaterally symmetrical ulcerations over the medial malleoli (Fig 1B). The skin of the dorsa of both feet was thin, atrophic, and taut with spotty hyperkeratosis over the bottom of the heels. The patient was unable to plantar flex his feet but able to dorsiflex 15 to 20 degrees. Ophthalmologic examination revealed circumscribed axial posterior subcapsular opacities. Indirect laryngoscopy was negative.

Laboratory findings: hemoglobin, 14.7 gm/100 ml; white blood cell count, 7,550/cu mm; erythrocyte sedimentation rate, 28 mm/hr; VDRL, negative; serum cholesterol, 174 gm/100 ml; Ca, 10.2 mg/100 ml; serum phosphorus, 3.5 mg/100 ml; fasting blood sugar, 76 mg/100 ml; glucose tolerance test, normal; basal metabolic rate, 11%; urinary 17-ketosteroid, 7.5 mg/24 hr. Chest, lumbar spine, sacroiliac, and hip joints were within normal limits on roentgenographic examination. The roentgenograms of the feet showed moderate osteoporosis. Electrocardiogram was interpreted as normal. A skin biopsy obtained from the dorsum of the foot disclosed only atrophy of epidermis and a relative

Fig. 1C—Werner's syndrome: Atrophic epidermis and decrease of appendages (time of first admission) (x120).

Fig. 2B—Werner's syndrome: medial malleolar ulcerations.

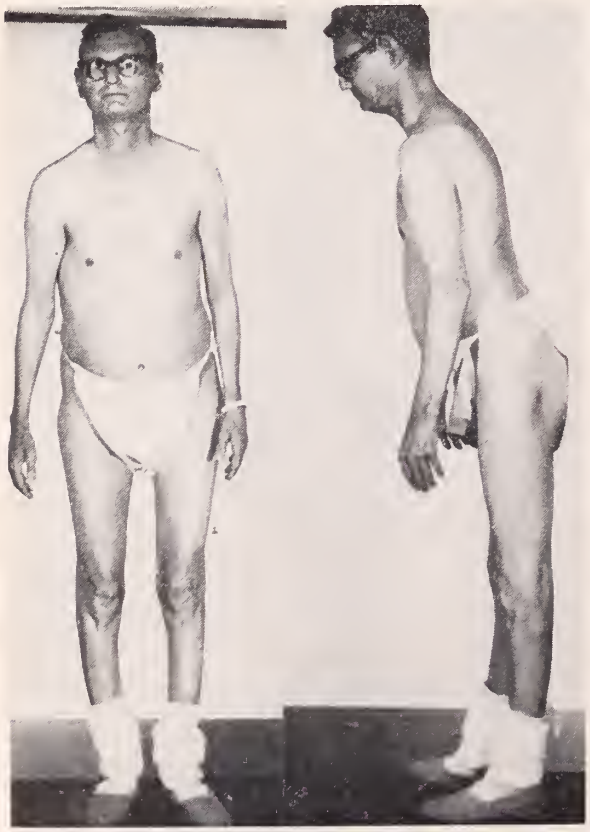


Fig. 2A—Werner's syndrome: body habitus at age 44 years.

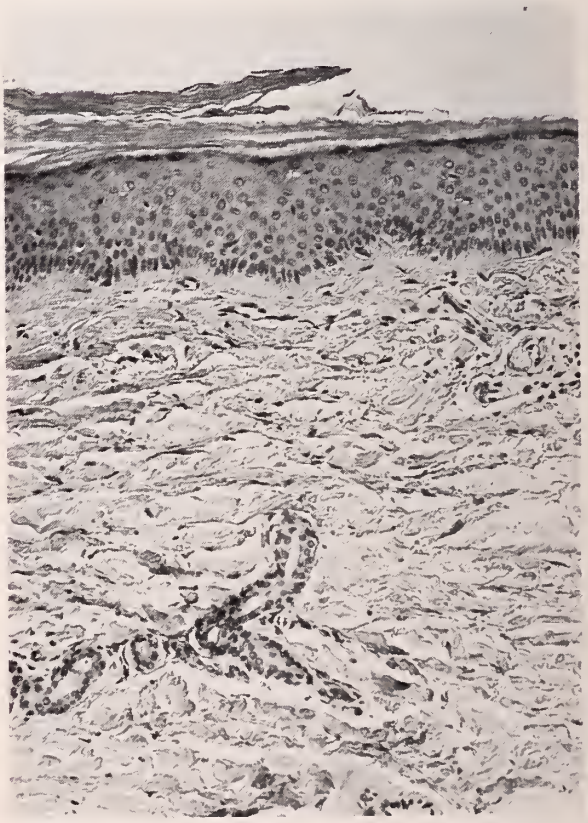


Fig. 2C—Werner's syndrome: section of skin showing slight epidermal atrophy and diminution of skin appendages (x120).

decrease in the number of dermal appendages (Fig 1C). He was discharged from the hospital with a diagnosis of Werner's syndrome.

Ten years later, in June 1966, the patient, now 44 years old, was again admitted to the hospital for treatment of chronic malleolar ulcers, which had become progressively larger and painful over the preceding 10 months. The ulcers never completely healed during the previous 11 years. One year previously the cataract in the right eye had been extracted. He now had six children, 3 to 18 years of age, and photographs of these children indicated all to be of apparently normal stature and growth.

On physical examination the patient was an alert man, five feet, eight inches tall, 120 lb, and blood pressure that was normal. Most striking were the peculiar wide-based lordotic stance and the now much more stocky trunk and spindly extremities (Fig 2A). His face was thin with a beaked nose, tightly drawn skin, and staring protruding eyes. There were only slight thinning and greying of the scalp hair. Body and axillary hair were scant. There were right aphakia and total lenticular opacity on the left. There were large, 2 cm x 6 cm ragged, deep ulcerations bilaterally over the medial malleoli (Fig 2B).

The patient now ambulated with a wide-based gait with the feet everted and knees fully extended during stance, and he had to flex his trunk to bring the body over his feet. Due to extreme skin contraction the feet were fixed in dorsiflexion and markedly everted. These changes were interpreted to be the cause of the peculiar abnormal, duck-walk waddle. Electromyographic studies were interpreted as borderline on the basis of low voltage and poor summation of medial gastrocnemius and extensor hallicus longus muscles, probably reflecting disuse atrophy. There was no evidence of a neuropathic or myopathic lesion.

Laboratory findings were normal except a slight increase in Beta globulins on electrophoresis of serum proteins; blood total lipid elevated to 1010 mg/100 ml; thymol turbidity 16.7 units; zinc sulfate turbidity 20.3 units; erythrocyte sedimentation rate 52 mm/hr (Westergren); urinary 17-hydroxy corticoids, 12.3 mg/24 hr; fasting blood glucose, 97 mg/100 ml; and two-hour postprandial blood sugar 114 mg/100 ml. Glucose tolerance test was now abnormally elevated at ½, 1, and 2 hours (Table 1).

Comparison with 1956 (10 years previous) laboratory results indicated an elevation of serum cholesterol level from previous 174 mg/100 ml to 266 mg/100 ml.

TABLE 1—*Glucose tolerance test*

Date	0	1/2	1	2	3
2-6-56	76	113	76	64	59
5-9-66	105	282	204	138	61

Roentgenograms of pelvis and spine revealed a diffuse and spotty osteoporosis not present 10 years previously. Calcification of abdominal aorta was now evident. Roentgenograms of the feet and legs disclosed much more extensive demineralization and cortical thinning but with preservation of joints compared to 10 years previously.

The vocal cords were of normal length with minimal keratinization, only slight atrophy of the mucosa over the vocal cords, and there was some oral mucosal atrophy. The nasal mucosa showed spotty areas of keratinization and a 1 to ¼ cm anterior septal perforation of nasal septum.

The electrocardiogram now showed nonspecific T wave inversion and changes indicative of left ventricular hypertrophy.

Tissue biopsy was performed on the lower leg in the area of scleroderma-like changes and revealed slight epidermal atrophy, moderate thinning of the dermis, slight fibrosis, and no fibrinoid necrosis or hyalinization of blood vessels (Fig 2C).

Treatment while in the hospital consisted of bed rest, 0.5% cysteine hydrochloride in normal saline compresses to the ulcers during the day alternating with scarlet red and Elase debridement dressings during the night. Good granulation tissue formed, with only a clean shallow ulceration remaining at time of discharge from the hospital. He was discharged on the following regimen: (1) high protein diet, (2) topical oxytetracycline (Terramycin) powder with absorbable gelatin sponge (Gelfoam), Ace rubber bandage during day, and scarlet red ointment dressings at night, (3) methyltestosterone, 10 mg, twice a day; ferrous sulfate tablet, twice a day; vitamin-E tocopherol, 45 units three times a day; and a therapeutic vitamin capsule daily. Six months after discharge the ulcers were healing slowly with marginal epithelization even though the patient had returned to work.

Discussion

The skin and soft tissues in our patient are characteristic of those reported in Werner's syndrome (Table 2). The profound wasting of the musculature of the feet, legs, and face are typical. Electromyography has been reported on three other cases, one showing reduced potentials as did our patient,[6] and two had normal potentials.[5, 7] The subcutaneous tissue and muscle depletion over the face and distal extremities are reflected clinically in the tight, smooth, shiny, atrophic skin over these areas. Since joint spaces are well preserved in the lower extremities in this patient, the eversion and plantar flexion of the feet are considered to be due to the extreme skin tension. This taut skin produces the thinness and tissue loss and sharpening of the nose contour, and makes the eyes appear protuberant and star-

TABLE 2—*Major manifestations of Werner's syndrome*

I. Skin and Soft Tissue
- a. Poor muscle development—extremities
- b. Premature baldness and graying of hair
- c. Subcutaneous tissue atrophy—face and extremities
- d. Tightness of skin—face and extremities
- e. Soft tissue calcification

II. Skeletal
- a. Short stature—arrest of growth at puberty
- b. Thinness of extremities, stocky trunk
- c. X-ray changes—osteoporosis, neurotrophic bone changes, osteomyelitis-like lesions, gross foot deformities, peripheral joint osteoarthropody, spondylosis deformans

III. Ocular
- a. Bilateral cataracts—onset third to fourth decade

IV. Vascular
- a. Peripheral atherosclerosis, arteriosclerosis, medial calcinosis
- b. Calcification of heart valves
- c. Coronary artery disease
- d. Superficial telangiectases

V. Endocrine
- a. Hypogonadism
  - Male: small testes, penis, prostate, decreased pubic and axillary hair
  - Female: poorly developed genitalia, ovaries, breasts, small uterus, irregular or absent menses, early menopause, scanty pubic and axillary hair
- b. Diabetes

VI. Miscellaneous
- a. High-pitched voice
- b. Slightly elevated cholesterol levels
- c. Normal mentality
- d. Recessive genetic pattern
- e. Increased incidence of mesenchymal neoplasia

ing, resulting in the typical bird-like facies seen in this syndrome. The deficiency of generalized body hair and axillary hair in this patient is typical, although he does not show the extensive baldness, loss of eyebrows and extreme poliosis usually found at this age in Werner's syndrome. Approximately one-third of these patients show radiographic soft tissue calcification, principally involving the tendons and ligaments of the knees, elbows, and ankles.[5]

Striking evidence of skeletal changes are evidenced here by the extreme thinness of the extremities and the bizarre combination of the stocky body with small hands and feet. Our patient is five feet, eight inches tall, which is within the range of all reported cases, but much taller than the 5′1″ mean for males, and 4′9½″ mean for females.[5] Deformities of the feet are common, and the pes planus in the patient is considered a part of the syndrome. His pronounced generalized and patchy osteoporosis, and its progression over 10 years as seen by roentgenogram, are typical of the advancing progressive nature of the dystrophic osseous process. This has

TABLE 3—*Chronology of symptom onset*

	Mean age of onset
Graying of hair	20
Skin changes	25.3
Premature hair thinning	25.8
Voice changes	26.6
Cataracts	30
Skin ulcers	33
Diabetes	34.2
Age at diagnosis	38.7
Age at death	47

Adapted from data by Epstein *et al*[5]

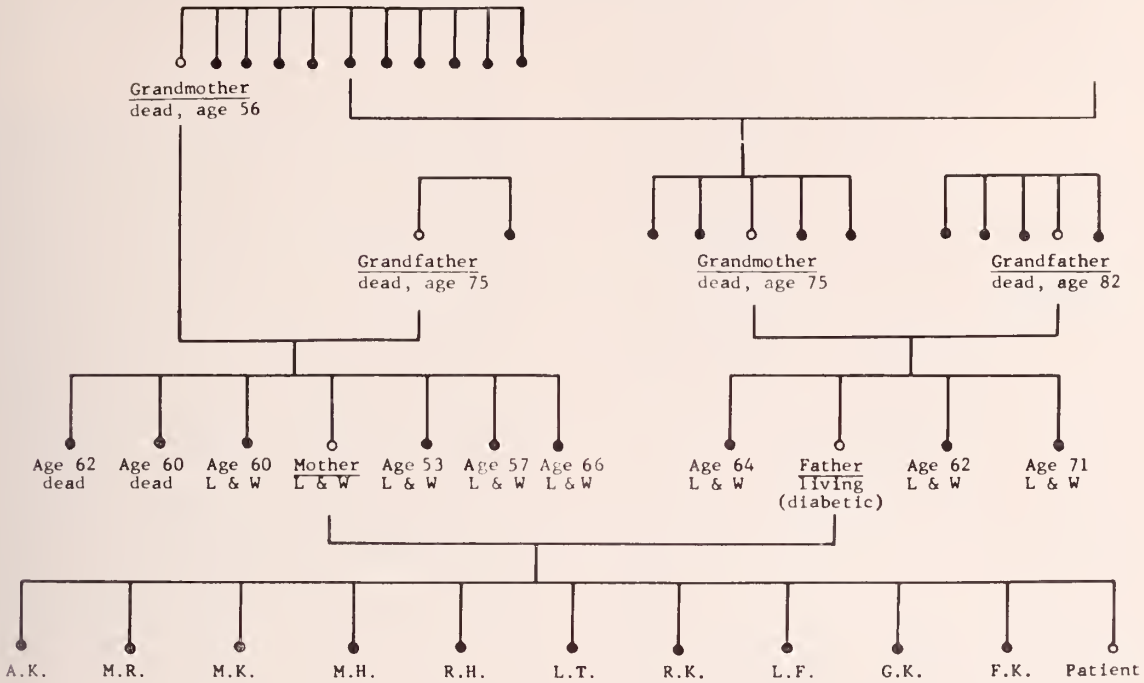
been found in approximately one-half of the patients as affecting feet, ankles, and lower legs most severely, but always sparing the skull.[5] The apparent extensive disturbance in calcium metabolism has been studied by several investigators, but no significant pattern of biochemical changes has emerged. Other radiographic skeletal changes, not present in this patient, which have occasionally been reported, consist of neurotrophic bone changes, osteomyelitis-like lesions, osteoarthritic lesions of the peripheral joints, and spondylosis deformans of the spine.[8]

A cardinal feature of Werner's syndrome is the development of bilateral, premature cataracts of the dystrophic type. Age of onset is usually in the 20-to-30-year age group, and the defect is usually posterior cortical and subcapsular. The onset and development of this bilateral cataract are usually rapid. Though bilateral, the two cataracts are not synchronous. They are believed to differ pathologically from the cataracts of aging which are usually nuclear and mature slowly.[9] Buschke[10] classifies these as dystrophic cataracts in the same category as those seen in Rothmund's syndrome, in atopic eczema, and in Darier's disease. They are similar to radiation-induced cataracts.[10]

Vascular arteriosclerotic changes, as evidenced by radiographic abdominal aortic calcification, were present in our patient. In many previously reported patients, severe generalized vascular atherosclerosis, medial calcinosis, interstitial fibrosis, and hyaline arteriosclerosis have been described. Calcification of aortic or mitral valve leaflet rings are also reported in all autopsied cases.[5] Coronary artery disease develops frequently, and should be anticipated.

The hypogonadism, evidenced here by small testes and penis, decreased pubic, axillary and body hair, and by decreased 17-ketosteroid excretion, are typical findings in male patients with Werner's syndrome.

TABLE 4—*Family pedigree*



Female patients have been described as having small external genitalia, small ovaries, and uterus, and scanty pubic and axillary hair. History of irregular or absent menses with early menopause (at mean age of 33) are common. There is some indication there might be decreased fertility, since 45 previously married patients had only 51 children.[5] Our patient is quite atypical with six children.

The incidence of diabetes varies according to different investigators and the criteria used for diagnosis. Epstein[5] reported the incidence as 44.4%. Irwin and Ward[11] said 20% have overt diabetes, and Field and Loebe[6] stated that the incidence is 65% when the glucose tolerance test is used. The diabetes is the adult-onset type, but it differs in that fasting blood sugar levels are quite often normal and response to insulin is poor. The diabetes is usually mild, without ketosis, and it responds well to diet and oral hypoglycemic agents. Field and Loebe[6] interpret these findings to indicate the defect is not one of insulin lack but caused by impaired peripheral utilization of carbohydrate related to the lack of muscular and subcutaneous adipose tissue. It is possible that the osteoporosis, subcutaneous calcification, hypogonadal features, diabetes, and arteriosclerosis are evidence of an endocrine abnormality in Werner's syndrome. Since all endocrinologic studies have been without significant results, most investigators now feel these changes are due to basic tissue metabolic defects.[12]

The thin, high-pitched voice, as found in our patient, has been noted in approximately one-half of reported cases. Where laryngoscopy has been performed, faulty movement, atrophy, or prominent vasculature of the vocal cords were noted in one-half of the patients.[5] Our patient has some atrophy of the mucosa of both the hypopharynx and oral cavity. The nasal hyperkeratosis and nasal septal perforation as seen in this patient has not previously been reported; we are not certain that this is related to the syndrome.

The life span of patients with Werner's syndrome is short. The range is from 31 to 63 years, with a mean age of death at 47 years (Table 3). Malignant tumors (in 10%) and vascular accident (in 2.4%) are causes of death.[5] It is notable that cutaneous carcinoma has never been recorded in these patients and that the most commonly reported malignancy is sarcoma.

TABLE 5—*Comparison of Werner's and Rothmund's syndromes*

	Werner's	Rothmund's
Similar findings:	Short stature, recessive inheritance, scanty scalp and eyebrow hair, involvement of skin and lens (cataract), hypogonadism	
Differences:		
1. Age onset	20–30 years	3 months–4 years
2. Skin	Tightly drawn, atrophic, ulcerations	Reticulated lesions proceeding to telangiectasia, scaling, pigmentation
3. Cataracts	20–30 years	2–6 years
4. Sex incidence	Equal	Predominately female
Features characteristic to one but not other:	1. Diabetes 2. Premature hair loss 3. Canities 4. Osteoporosis 5. Arteriosclerosis 6. Pronounced musculo-skeletal changes 7. Proptosis	1. Congenital bone defects 2. Sensitivity to sunlight 3. Defects in nails and teeth

Buccal smears and chromosome studies on 6 previously studied patients[11] as well as our patient have been chromatin-negative and karyotype-normal. Therefore, it has been postulated that the syndrome is a disorder of genes rather than of gross chromosomal aberration. Sex limitation or linkage is not likely, in view of the nearly 1:1 sex ratio.[5] In evaluating consanguinity in 87 siblings, Epstein[5] found consanguinities in 17, no consanguinity in 30, and no information in 40. In view of the large number of sibling patients and this high incidence of consanguinity a recessive inheritance is likely. Since manifestations of Werner's syndrome are very infrequent in the parents of the patient, the heterozygote expression is minimal. The maternal grandmother of our patient was an aunt to his paternal grandmother, thus making his parents second cousins. None of his siblings have similar symptoms (Table 4).

Pathology

The clinically sclerodermoid skin in Werner's syndrome, on histologic evaluation has none of the adventitial sclerosis, vascular occlusion, homogenization and fusion of collagen or fragmentation of elastica usually found in true scleroderma. The picture is rather that of a seeming atrophy of the epidermis as evidenced by a reduction in thickness of the stratum malphigi and a decrease in thickness and quantity of rete ridges. There is atrophy of skin appendages, especially the hair follicles and sebaceous glands, a decrease or absence of aerolar tissue around the appendages and atrophy of the subcutaneous fat. Focal benign hyperkeratoses are often reported. Dermal fibrosis seems to be variable.[13, 5]

Elastic stains usually show decreased elastic fibers in the papillary cutis and "parallel banding" of elastic tissue in middle and lower cutis.[13] Use of the Van Kossa stain sometimes enables one to see a certain small amount of calcium deposit among the elastic fibers, but never approaching the degree found in pseudoxanthoma elasticum.[13]

In addition to the skin, several investigators have demonstrated pathologic changes in genitourinary, cardiovascular, and muscular tissues. Cardiovascular pathology consists of severe arteriosclerosis, atherosclerosis, medial calcinosis, hyaline arteriosclerosis, calcification of aortic and mitral valves (in all autopsied), and atrophy with fibrosis of myocardium. There was moderately severe testicular atrophy in all autopsied cases with a severe amount of hyalinization of the seminiferous tabules.[5]

Differential Diagnosis

Several diseases have significant features which overlap with those of Werner's syndrome, but in all there are critical differences.[4] The similarities and differences of Rothmund's syndrome, with which it is most often confused or identified in the literature, are given in Table 5. The Progeria of Childhood, (Hutchinson Guilford's syndrome) has similar features of dwarfing, subcutaneous fat atrophy, severe arteriosclerosis and osteoporosis, and typical facies. It differs however in its very early onset of 3 months to 4 years of age, and the absence of cataracts, hyperkeratoses, skin ulcers, and diabetes. Myotonc dystrophy has similar features: onset in second or third decade, cataracts, premature baldness, and a tendency to diabetes. Myotonia dystrophica is easily distinguished by myotonia and absence of cutaneous changes.

Scleroderma differs in that it is characterized by progressive hardening of the skin of the face and extremities, Raynaud's phenomena, esophageal and pulmonary fibrosis, and no hereditary tendencies or hyperkeratoses. The histologic findings in scleroderma—edema, inflammation, and fibrosis with sclerotic obliteration of arterioles—are not found in Werner's syndrome. In the Hydrotic Ectodermal Dysplasia syn-

drome, which resembles Werner's syndrome only by presence of alopecia, there is no loss of subcutaneous or muscular tissue and no cataract.

Etiology

Investigations into the etiology of this syndrome have not revealed a definite cause. Werner's[1] original theory of purely ectodermal cell failure has been discarded because of the extensive mesodermal involvement.

Thannhauser's theory[4] of multiple germ plasm defects is no longer accepted by most authorities.

That Werner's syndrome is based on a primary endocrinopathy has been proposed by Oppenheimer and Kugel[3] and Smith *et al.*[13] However, no single endocrine theory can explain all the features of Werner's syndrome.

In view of the incidence of consanguinity and occurrence in siblings, the presently most acceptable theory is that it is genetically transmitted in a recessive pattern. The hereditary defect may well be an enzymatic abnormality which is causing the varied and seemingly unrelated components of Werner's syndrome, but no objective evidence has come to light.

According to Epstein,[14] Werner's syndrome probably represents more than simple premature physiologic aging. The atherosclerosis, arteriosclerosis, medial calcinosis, graying of hair, hypermelanosis and cerebral and lymphoid atrophy are features of physiologic aging found in Werner's syndrome. The calcification of valve leaflets, hyalinization of seminiferous tubules, atrophy of skin appendages, the osteoporosis, and generalized loss of hair are also present but more severe in Werner's syndrome. Features which seem unique to Werner's syndrome, and not seen in physiologic aging, are the dystrophic subcapsular and cortical cataracts, the ulceration of the extremities, shortness of stature, increased incidence of sarcomas, prostatic atrophy, and soft tissue calcifications.

In respect to etiology it is notable that recently experimental progeria in animals (young rats) has been produced by Selye[15] with low doses of dihydrotachysterol. In a series of experiments he showed that DHT-induced progeria in animals can be prevented with methyl-testosterone or ferric dextran.

Whatever the etiology, the syndrome has a fascinating diversity in its expressions: (1) the growth defects during adolescence, (2) the inexorable degeneration of tissues that previously functioned adequately, and (3) the association with increased incidence of mesenchymal tumors, which suggests an aberration in the physiologic control of connective tissue.

Summary

Werner's syndrome, as exemplified by the clinical and pathologic findings in a man, 44 years of age, is characterized and distinguished by recessive inheritance, rapidly progressing cataracts, progressive osteoporosis, diabetes mellitus, severe arteriosclerosis, mucosal atrophy, atrophy of the skin with extreme cutaneous tightening and resulting disabling deformities of the extremities. The syndrome is unique. The etiology is unknown, and the pathologic physiological mechanisms producing the tissue defects are not understood.

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Family Outbreak of Mycoplasma Pneumoniae

By PAUL M. COX, JR., M.D. and H. GRANT SKINNER, M.D., M.P.H., Madison, Wisconsin

■ IN RECENT YEARS, *mycoplasma pneumoniae* (formerly known as Eaton agent) has become recognized as an important cause of respiratory illness in man. Recent studies indicated that mycoplasma pneumoniae was responsible for 7% to 20% of all febrile respiratory disease among the patients of a Seattle medical group, both as primary atypical pneumonia and as upper respiratory infections.[1,2] Other mycoplasma species have long been recognized as pathogens in birds and mammals.[3] Mycoplasma species have been implicated in nonrespiratory diseases of man including a possible etiologic role in urethritis,[4] meningoencephalitis,[5] and myringitis.[6]

Only recently has the epidemiology been well documented as occurring in family outbreaks. The present report is a description of a similar family outbreak of m. pneumoniae infection which we recently investigated. This outbreak was kindly brought to our attention by Dr. George G. Stebbins (now deceased), the family physician, and Dr. Charles K. Kincaid, Madison City Health Officer.

Case Reports

About July 4, 1967, an 11-year-old boy and his 2-year-old sister became ill with a respiratory illness characterized by malaise, fever, and persistent, nonproductive cough. They were still ill but convalescing well on July 11, when their 19-year-old brother arrived home on leave from the armed services. About July 14, the 41-year-old father of the family and an 18-year-old girl who was living with the family as a babysitter at the time, also became ill with febrile respiratory illnesses. They also did not see a physician; their illnesses each lasted approximately one week and then subsided spontaneously.

On July 26, 1967, the 40-year-old mother became ill with fever and cough. She finally saw her physician one week later, by which time she had lost approximately 10 lb. Her temperature was 102.8 F, p.o.; the only other positive physical findings were scattered rales over both lung fields. Chest x-ray film showed a miliary pattern throughout both lung fields with two large well-calcified right hilar lymph nodes. Histoplasmosis skin test was positive; other fungal skin tests and intermediate PPD were negative. Because of these findings and a recent, annoying exposure to pigeons, miliary histoplasmosis was initially considered. However, laboratory data (Table 1) excluded this diagnosis and confirmed that of m. pneumoniae infection. She subsequently had an uneventful recovery and the miliary pattern on chest x-ray film remained unchanged.

The 19-year-old son became ill on Aug. 7, 1967, with chills, fever, and cough productive of scanty amounts of thick, foul-tasting, gray sputum. Chest x-ray film on admission to a military infirmary showed a lingular infiltrate and he was treated with penicillin for the presumptive diagnosis of pneumococcal pneumonia. Sputum cultured at that time grew only usual mouth flora. On the sixth day of illness he was still febrile and coughing, and he was transferred to another hospital. On admission there, he was described as a well developed white man in moderate distress with a temperature of 102.0 F, p.o. His physical examination was unremarkable except for fine left basilar rales without signs of consolidation. His chest x-ray film showed an additional area of fluffy infiltrate in the right basilar area. A complete blood count was reported as hematocrit 44%, white blood cells 12,800/cu mm with a differential count of 77 segmented neutrophils, 6 band forms, 13 lymphocytes, and 4 monocytes. Cold agglutinins were 1:16. Tetracycline was added to the penicillin therapy. On the following day he became afebrile and remained so for the rest of his hospital stay. He was seen by us on the fourth hospital day at which time he was afebrile but still subjectively weak and became diaphoretic on minimal exertion. The only abnormal physical findings were bi-basilar rales without evidence of consolidation. Cultures of sputum and a throat swab taken on the following day, five days after the initiation of tetracycline therapy, were both positive for mycoplasma pneumoniae.

No other of the family's limited contacts were ill during this time.

Mycoplasma pneumoniae were isolated from three members of the family (Table 1). Another member had a drop in C.F. titer from early convalescence to late convalescence and a fifth had a single elevated convalescent titer. These data plus the clinical and epidemiologic evidence suggest that all six

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TABLE 1—*Laboratory studies*

	Complement Fixation						Culture			
	Mycoplasma Pneumonia			Histo-plasmosis	Psittacosis		Throat			Sputum
Date	8/17	8/30	9/6	8/17	8/17	9/6	8/18	8/30	9/6	8/18
Patient (age)										
Mother—40	1:64		1:32	<1:8	<1:8	<1:8	Neg	+		-
Son—19	1:8		1:64	<1:8	<1:8	<1:8	+		+	+
Father—41	1:8		<1:8	<1:8	<1:8	<1:8	—	Neg		
Son—11		1:16						Neg		
Daughter—2			1:32					+		—

members of the household were ill with mycoplasma pneumoniae infections of the respiratory tract.

This family outbreak demonstrates many only recently recognized clinical and epidemiologic aspects of mycoplasma pneumoniae infections. The first four members of the family were significantly ill with fever and upper respiratory symptoms but were not ill enough to seek a physician's aid. The mother was rather severely ill for over a week with considerable weight loss and systemic symptoms. The unfortunate coincidences of recent, annoying exposure to pigeons and skin test and x-ray evidence suggesting histoplasma infection obscured the cause of her illness initially. Her 19-year-old son, on the other hand, had the classic course of mycoplasma pneumonia—"atypical" pneumonia in a healthy young person which does not respond to penicillin and does respond to tetracycline or resolves spontaneously.

Of significance is the fact that m. pneumoniae could be cultured two months after onset of the disease in the 2-year-old child and one month after onset of the disease and adequate treatment with tetracycline in the 19-year-old son. Shedding of m. pneumoniae after tetracycline and erythromycin therapy is apparently quite common and may be associated with recurrence of illness.[7]

Comment

This outbreak corroborates the available evidence that spread of the disease usually occurs only after intensive exposure. Thus, the entity was first described and has been most thoroughly studied in military populations.[8] Outbreaks in a nuclear submarine[9] and among university students have been well described.[10] Foy *et al*[11] recently described the epidemiology of m. pneumoniae in civilian families. Of 36 index cases, 23 transmitted infection to their families. In these 23 families, attack rates were 84% in children and 41% in adults. Median incubation period was 23 days.

One difficulty inherent in comparing military, school, and other civilian studies is that frequency of mycoplasma infection varies greatly from time to time in the same area and in similar populations. Thus, although usually more prevalent in fall and winter (although this outbreak occurred in midsummer) mycoplasma infections vary greatly in frequency from year to year in the same population. The most remarkable example of this was documented among Parris Island recruits. In 1959 mycoplasma pneumoniae accounted for 67% of the atypical pneumonias in this population. This decreased steadily until 1963 when m. pneumoniae accounted for only 7%.[8] This difference was not due to a clear-cut epidemic during the former year—clear-cut, widespread epidemics of m. pneumoniae (unlike influenza and other viral respiratory illness) rarely occur, although they have been described.[12]

M. pneumoniae vaccine has been prepared and is being tested. Although this may become useful in military populations, it is unlikely that this will become of general use in civilian populations.[13]

ACKNOWLEDGMENT: The Wisconsin State Laboratory of Hygiene kindly performed all the laboratory determinations. In particular, we would like to thank Miss Virginia Allen and Miss L. Goggins. Their expertise in the laboratory diagnosis of mycoplasma and histoplasmosis, respectively, made this study possible.

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PRIMARY ALDOSTERONISM

JAMES C. MELBY: *Practitioner* 200:519 (Apr) 1968

Primary aldosteronism (the association of arterial hypertension and potassium depletion owing to excessive aldosterone secretion by an adrenocortical adenoma) accounts for many cases of hypertension and is curable. Removal of the offending adenoma results in remission of hypertension and repletion of potassium stores.

Uncertainty in the diagnosis of primary aldosteronism has increased with the recognition of hypertensive disorders in which there is disturbed regulation of aldosterone secretion, presumably due to heightened activation of the renin-angiotensin system. In these disorders, excessive aldosterone secretion is referred to as secondary aldosteronism, and hypertension is not relieved by adrenalectomy.

All of the complications of long-standing hypertension have been noted in patients with primary aldosteronism. The most obvious clinical manifestations of primary aldosteronism are due to prolonged, excessive renal potassium wastage. Nocturnal polyuria and polydipsia are common signs of the potassium deficiency. Restriction of sodium leads to potassium retention and improves hypokalemic symptoms. Acute precipitation of potassium depletion by thiazide diuretics in the treatment of a hypertensive patient should suggest immediately the possibility of primary aldosteronism.

Difficulties in screening hypertensive patients for primary aldosteronism have been increased by the recognition of "normokalemic" primary aldosteronism. Hypokalemia induced by sodium loading is important indirect evidence of sustained excessive aldosterone secretion and may be a reliable screening method in hypertensive patients. The positive screening test for the presence of aldosteronism should then be confirmed by the measurement of aldosterone secretion or excretion on controlled sodium intake and activity. This provocative test does not differentiate primary aldosteronism due to an aldosterone-producing adrenal cortical adenoma from secondary aldosteronism due to disturbed regulation of aldosterone secretion.

Primary aldosteronism may be differentiated from secondary aldosteronism by measurement of plasma renin activity and blood pressure response to spironolactone administration. Depressed plasma renin activity in an erect active patient with aldosteronism is a highly reliable indication of the presence of an aldosterone-producing adenoma. A characteristic finding in hypertensive patients with secondary aldosteronism is significantly elevated plasma renin activity after prolonged recumbency.

Spironolactone, 400 mg/day or more, given for a protracted period to patients with hypersecretion of aldosterone and severe arterial hypertension reduces the blood pressure significantly in patients with primary aldosteronism, but does not affect to the same extent the blood pressure of those with secondary aldosteronism. Although the spironolactone response test distinguishes primary from secondary aldosteronism, it does not distinguish essential hypertension with normal aldosterone production from primary aldosteronism.

Diagnosis of aldosterone-producing tumors can be confirmed and localization of the tumor may be accomplished by comparison of aldosterone levels in blood from right and left adrenal veins. The concentration of aldosterone in the venous blood from uninvolved glands is usually below 1 μg percent and more than 3 μg percent in effluent from the tumor-bearing gland.

In primary aldosteronism, removal of the adenoma results in cure of the hypertension in most instances. Spironolactone therapy should be carried out for three to five weeks before surgery, because repletion of potassium stores is essential for optimal operative response and because the period of postoperative aldosterone deficiency which results from prolonged suppression of the reninangiotensin system is abolished by administration of spironolactones.

TEENAGERS DANCING . . .

to the pounding beat of rock'n roll bands are blasting their eardrums prematurely into old age, a University of Florida researcher said recently. In front of the bandstand of a Gainesville teenagers' club, his team found the noise measured 120 decibels—as loud as the Saturn 5 moon rocket measured from the press site at Cape Kennedy.—From GP, March 1968

Therapeutic Dilemmas

No. 13 of a Series

Editor:

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COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

COMPLICATED RHEUMATOID ARTHRITIS

Moderator: John O. Chamberlain, M.D.
Participants: P. David Lemper, M.D.
Douglas D. Klink, M.D.
Charles Locher, M.D.
Harry A. Easom, M.D.
R. C. Danforth, M.D.
Gerson C. Bernhard, M.D.

Dr. John O. Chamberlain: The patient under consideration this morning, a 50-year-old white woman, is one whose rheumatoid arthritis has been complicated in so many ways as to make her a real therapeutic puzzle. Her troubles began about six years ago with occasional aching in the right shoulder and wrist on arising; but the really severe arthropathy developed only three years ago in the form of a bilaterally symmetrical polyarthritis involving most joints but most prominently the knees and ankles. At this time she was treated with corticosteroids and developed diabetes soon thereafter. One year ago, in August 1966, she was hospitalized with pleuritis in another city, where prednisone (Meticorten) was substituted for betamethazone (Celestone) and insulin therapy was begun. Subsequently she has been cared for by Doctor Klink, whose attempts to taper off prednisone have been unsuccessful. In the past six months other complications have developed: episcleritis, paresthesias in the lower legs and feet, skin alterations, nodular petechial lesions on the tips of the fingers and toes. Doctor Lemper will present the physical and laboratory findings obtained here in this hospital.

Dr. P. David Lemper (Resident in Medicine): On admission, in July 1967, the patient was observed to have a round face; truncal obesity; mottled violaceous discoloration of the skin, particularly of the extremities; bilateral cataracts and episcleritis; synovial sponginess and thickening of all peripheral joints; atrophy of the hand muscles; deformity of the hands and fingers; and diminution in the touch, pain and vibratory sensations in the feet. Most tendon reflexes were absent. The blood pressure was 110/65 mm Hg and the urine findings were normal. Hemoglobin was 14.7 gm/100 ml, hematocrit 45%, white blood cell count, 12,800/cu mm with normal differential, erythrocyte sedimentation rate 68, LE cell test normal. Total serum protein was 6.4 gm/100 ml, albumen/globulin ratio reversed. Blood urea nitrogen, creatinine, calcium, phosphate, and alkaline phosphatase were all normal. Rheumatoid factor was present in a titer greater than 1:10,240.

Muscle biopsy revealed atrophy and some demyelinization with some lymphocytes present in the adventitia of vessels, findings that were interpreted as those of minimal chronic vasculitis. An electromyogram revealed a decreased number of motor units.

The patient was treated with prednisone, aspirin, denatured proteolytic enzymes (Protamide), diphenylhydantoin (Dilantin), and insulin. On the 30th hospital day she developed fever of 102.4 F, which came down and then spiked again twice. Lincomycin (Lincocin) appeared to prevent its return. She is still hospitalized, experiencing greatest distress during early morning.

Dr. Chamberlain: Doctor Locher, will you kindly present the x-ray findings?

Dr. Charles Locher (Resident in Radiology): Both knee joints show considerable periarticular osteoporosis. There is also some narrowing of the joint spaces, most prominently on the medial aspect of the right knee (Fig 1). There is also soft tissue (i.e., synovial) swelling about the joint space it-

Fig. 1—Right knee, showing periarticular soft tissue swelling, mesial joint narrowing, synovial swelling.

self. These are early changes, not characteristic exclusively of rheumatoid arthritis; but when you get into the hands the diagnosis can be made (Fig 2). Here the "paint brush" effect of the periarticular osteoporosis is even more prominent than the evidence of generalized osteoporosis, and there are also a few small cystic changes, juxtaarticular and within the carpal bones. There is some periarticular soft tissue swelling here also, especially around the carpal joints. The distal ends of both radii show destructive changes. There were minimal degenerative changes in the lumbar spine but no evidence of rheumatoid disease, and the sacroiliac synchondroses were in fairly good condition —a little demineralized, but not destroyed, as may occur in rheumatoid arthritis. The epiphyseal joints were a little sclerotic but also not diagnostic of the disease.

Dr. Chamberlain: Doctor Klink, since you have the patient presently under your care would you like to make any comments?

Dr. Douglas D. Klink: The hyperglycemia, which developed while on corticosteroids before I saw the patient, was apparently controllable with tolbutamide (Orinase) originally. At the time of her hospitalization a year ago in another city, the attending physician obtained findings in aspirates of the bilateral pleural effusions which were typical of rheumatoid arthritis, namely a discrepancy between the amount of sugar in the blood and in the pleural fluid. His findings showed pleural sugar was 109 mg/100 ml when the blood sugar was 300 mg/100 ml. And at a second aspiration, when the blood sugar had been brought down to 110 mg/100 ml, the pleural sugar was less than 25% of this amount. Differences of this sort have always been intriguing to me and diagnostically helpful, but I do not understand their causation. During this hospitalization she also became very toxic; her blood pressure at one time fell to 80/50 mm Hg with a temperature spiking to 104.0 F. Antibiotic therapy did not effect relief but the use of corticosteroids in high dosage did. When discharged, the prednisone dosage had been reduced to 10 mg daily, but when I first saw her she was aching very severely and it was necessary to raise the dosage to 15 mg daily.

At the other hospital it was necessary to use 50 units of insulin daily to control the diabetes; at present I can keep her urine negative and the blood sugar in very good range with 40 units daily. If we could ever discontinue the corticosteroids, it might be possible to discontinue insulin also. Unfortunately, however, this lady's maladies are progressing relentlessly. Shortly after she returned from the other hospital she had a diffuse eruption, which a dermatologic consultant showed to be due to monilial infection; it cleared promptly under micostatin powder and cream. Then she developed cataracts, followed by episcleritis, and in May of this year (just about three months ago) she began to suffer from numbness and tingling paresthesias in both lower extremities of such severity that hospitalization finally became necessary. When I first saw her, a year ago, she had good ankle and knee jerks, but after the peripheral neurologic symptoms appeared the knee jerks disappeared. Since her hospitalization the paresthesias have lessened but the areas of numbness have increased. At the other hospital, needle biopsy revealed chronic organizing pleuritis with small collections of plasma cells, and in skeletal muscle near the cord investigators found one small vessel whose wall was damaged and appeared bright pink with surrounding

Fig. 2—Hands, showing juxtaarticular osteoporosis, cystic changes in carpals, destruction of distal radius, early ulnar notching on radius, synovial thickening at wrist.

chronic inflammatory cells. We have not been able to see these changes in biopsied gastrocnemius muscle here in this hospital.

Dr. Chamberlain: Thank you, Doctor Klink. Doctor Easom, would you like to discuss the ophthalmologic problems in this case?

Dr. Harry A. Easom: I was first asked to see the patient in January 1967 because of gradually decreasing vision during the preceding few months. There was no doubt about the presence of bilateral cataracts, but the question of their etiology was complex. Were these diabetic cataracts such as we sometimes see in juveniles, or cataracts of the presenile diabetic type, or were they corticosteroid induced, or finally, were they of the type that is alleged to be sometimes associated in a primary fashion with rheumatoid disease? The latter possibility I consider least likely. The cataracts are posterior subcapsular, which is the location of all the three types under consideration.

Then, more recently, she has developed the episcleritis that is still present. This is of the nodular type that is associated with rheumatoid arthritis, histologically a granulomatous inflammation surrounding foci of necrosis. This lesion is often refractory to corticosteroids and may be disastrous for the patient since the sclerae may be melted away with resultant perforation and loss of the eye. We have used topical in addition to systemic corticosteroids in this case without much benefit, and I am unable to predict the outcome.

An additional complicating factor in this patient is that the intraocular pressure has been found to be elevated on several occasions, and it is possible that the corticosteroids are responsible for this.

At this time the cataracts are ready for extraction, but I do not feel that the inflammatory process present in the eyes would make operation feasible. Indeed, if and when the episcleritis subsides, we may have to modify our technic of cataract extraction. People with this combination of problems (diabetes, nodular episcleritis, and increased intraocular pressure) do poorly with cataract surgery, in terms of delayed wound healing and postoperative complications. I am certainly not eager to proceed with surgery in this case. I feel that we may be forced into removing one or both of the cataracts eventually because the patient is becoming increasingly incapacitated visually.

A Physician: Were you able to visualize the retina?

Dr. Easom: She has some choreoretinal scarring in the periphery, which I do not think is attributable to any of the involvements previously mentioned. The maculae and the optic nerves are essentially within normal limits bilaterally, as seen through the hazy media.

Dr. Chamberlain: Thank you, Doctor Easom. Doctor Danforth will now discuss the case from the neurological standpoint.

Dr. R. C. Danforth: I was asked to see this lady about a month ago because of the peripheral neuritic symptoms. The onset of paresthesias, gradual diminution of the reflexes with sensory diminution progressing to complete sensory loss in the lower extremities, make the diagnosis of peripheral neuritis a rather easy one; but we are frequently at a loss to understand the etiology in particular cases when there is no associated systemic disease. In the present instance, however, we have a diffuse type of polyneuropathy involving no one nerve course but with a complete distal distribution, and we may choose between the vasculitis associated with rheumatoid arthritis and the metabolic alterations in diabetes as underlying the malady. It is impossible clinically to make this differentiation, but a muscle biopsy, including a piece of peripheral nerve, is often helpful. Actually the distinction is of somewhat academic importance except that when we are able to ascribe the malady to an underlying diabetes rather than to rheumatoid arthritis the prognosis

is much better, for these neuropathies frequently plateau and may improve in the diabetic.

Treatment for the neuropathy itself consists of treatment of the underlying disease and simply trying to make the patient comfortable, which is not always easy for this burning pain can often be excruciating and disabling. Chlorpromazine (Thorazine) and diphenylhydantoin (Dilantin) are sometimes helpful. In this patient we used diphenylhydantoin with considerable success.

A Physician: What is the rationale for the use of diphenylhydantoin?

Dr. Danforth: Diphenylhydantoin reduces the post-tetanic potentiation of synaptic transmission within the spinal cord and has a stabilizing action on all excitable membranes without interfering with the normal functions of excitable cells. Its original use in a neuropathy was in trigeminal neuralgia, in which it is somewhat helpful in about half the cases, and it is now being used in the amelioration of tabetic pain and in these peripheral neuritis cases.

A Physician: I have seen at least a half dozen patients with diabetic neuropathies who, after a year or a year and a half of severe pain, have ceased to have complaint on this score.

Dr. Danforth: It is certainly true that the pain in the diabetic is often more severe than in the rheumatoid and often later diminishes and even disappears, but this is not a helpful differential diagnostic point.

A Physician: What happens with regard to the neuropathy in a rheumatoid patient when corticosteroids are stopped?

Dr. Danforth: I cannot answer this question because I have never seen a patient in whom they could be stopped. The usual experience is for dosage to be increased and for the patient to worsen progressively anyway. About four years ago I had a patient in whom it was possible to diminish dosage somewhat, and he grew steadily worse.

Dr. Chamberlain: Thank you, Doctor Danforth. Doctor Bernhard will now discuss the case from the rheumatologist's standpoint.

Dr. Gerson C. Bernhard: I think there are clinical reasons for believing that this patient has vasculitis and that the biopsy might have revealed this had it been made at another site. At least at the Marshfield Clinic they found some evidence of vasculitis in their pleural biopsy. If one reviews all the reports of vasculitis, as was done exhaustively by Schmid and associates (F. R. Schmid, N. S. Cooper, M. Ziff and C. McEwen, *Am. J. of Med.* 30:56, 1961), it will be seen (1) that the patients usually have a rather severe and progressive form of rheumatoid disease; (2) that episcleritis is quite common; and (3) that it is reasonably common to see other evidences of systemic involvement, such as pleuritis or palpable spleens or clinical pericarditis.

Most of these patients have subcutaneous nodules, not only in the classic elbow site but also on the backs of the hands and at the fingertips. There is often considerable localized pain and then the nodule appears rather abruptly, after cessation of the pain, with petechial hemorrhage in its center. These really look like Osler nodes, but they are sitting in small subcutaneous nodules; I think that if they were to be biopsied, localized vasculitis would be revealed. Peripheral neuropathy is a quite common manifestation of rheumatoid vasculitis.

These people frequently have a lot of rheumatoid factor. How much more our present patient has than the titer of 1:10,240 that was mentioned will be left for determination at a later time. An electromyogram is sometimes helpful, since it may provide evidence of denervation or of myopathic changes, for a localized myositis is not unusual in the malady.

Prognosis is not good in rheumatoid vasculitis. The neuropathy becomes worse and so does the systemic involvement, and unquestionably the use of corticosteroids compounds the difficulties. I have seen cases of severe skin ulceration; and if larger vessels become involved there may be gangrene and loss of portions of limbs (very interestingly, this can occur in the presence of a good, palpable pulse). Finally, one of the involved areas becomes infected, and the patient succumbs because of lack of host resistance.

It is interesting to consider that if one relates the rheumatoid factor present in these patients with the vasculitis they have, the process may be conceived as being the human counterpart of the rabbit Arthus phenomenon. You will recall that the Arthus phenomenon is a vasculitis produced in the rabbit by sensitization with an antigen and subsequent injection locally of the same antigen after the precipitating antibodies that will bind complement have had time to form. The presence of polymorphonuclear leukocytes is necessary for production of this

phenomenon in the rabbit; there is evidence that leukocytes initiate the inflammatory process by release of their lysosomal enzymes. There is no proof that immune complexes are precipitated in the vessels of patients with severe rheumatoid disease. But it is a fact that rheumatoid factor unites with its probable antigen, aggregated or altered gamma globulin, and circulates as a soluble complex. If this is a harmful complex, it is rational to attempt to reduce the amount of rheumatoid factor as a therapeutic measure.

Corticosteroids will not effectively reduce rheumatoid factor. They will only suppress inflammation. The immunosuppressive agents that are employed against cancer are of theoretical interest because most of them combat antibody production, perhaps by selectively destroying the cells that produce the 7-S gamma globulin. Unfortunately, however, very few of them are effective against the cells producing large macroglobulins of rheumatoid factor. Our own modest experience with azothioprine (Imuran) has not been productive of results, and this has been the larger experience elsewhere.

Penicillamine (Cuprimine) is also of therapeutic interest, since it is both a chelating agent and a splitter of sulfhydril bonds. The rheumatoid factor molecule is made up of peptide chains linked together by sulfhydril bonds, which theoretically could be split off; and it appears that penicillamine will actually do this. However, the number of reports of effective use is still very small, and the drug presents difficulties of both toxicity and expense. Nevertheless, we are trying it in this present case and may have some sort of answer after several months.

A Physician: Why not stop the corticosteroids?

Dr. Bernhard: I certainly feel that if we could get this patient off corticosteroids she would be helped in many ways, but if we attempt to do this abruptly we will have a febrile, severely arthritic, very ill toxic patient on our hands.

A Physician: She's a very ill patient now.

Dr. Klink: I would remind you that when I first saw the patient last year she was suffering severe arthralgia after a reduction in corticosteroid dosage. I had to increase dosage at that time, but have subsequently succeeded in reducing it by half a milligram a month, which was all that she would agree to—and, in fact, during the winter months she would tolerate no reductions at all. At present, our 12.5 mg daily dosage of prednisone, equivalent to 60 mg of cortisone, is only 20 to 25 mg more than the normal adrenal cortex produces daily. I had hoped to have her off of corticosteroids in the hospital before this time, but her severe reactions have forced a slowing of the reduction process.

A Physician: Might it not be better never to start the corticosteroids at all? At the last meeting on rheumatology I attended, the statement was freshly written on the board each day throughout the week: "Steroids plus time equals increased morbidity and mortality."

Dr. Bernhard: I think the question resolves itself into this: do corticosteroids cause vasculitis? The evidence is still not clear. There is no doubt that most patients who have severe vasculitis have been on corticosteroids, and Johnson, Smyth and associates (R. L. Johnson, C. J. Smyth, G. W. Holt, A. Lubchenko and E. Valentine, *Arth. & Rheum.* 2:224, 1959) have pointed out that they have not only been on this therapy but have been on it a fairly long time with fluctuating dosage and a picture of severe, death-dealing vasculitis usually appearing as they are taken off the drugs. On the other hand, however, there is the evidence that non-rheumatoid individuals with long-standing Cushing's syndrome do not develop vasculitis; and patients who do not have rheumatoid arthritis but are on corticosteroids for long periods for other purposes do not develop it either. It seems clear that the patients who are most severely involved in a rheumatoid process are the ones who are getting the corticosteroids. They are being kept alive longer, which may permit the appearance of severe underlying vasculitis. The present patient, if left on corticosteroids, will start collapsing her vertebrae in all likelihood, and admittedly she may develop tuberculosis and other dire consequences of the therapy.

Dr. Chamberlain (summarizing): Today we have carefully considered a case of severely complicated rheumatoid arthritis, discussing the etiologic, immunologic, and prognostic aspects of this serious situation as well as the therapeutic dilemmas it presents.

COMMENTS ON TREATMENT

Presented through the cooperation of the Departments of Pharmacology and Medicine, Marquette School of Medicine, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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Current Management of Multiple Myeloma

By DONALD R. KORST, M.D., Madison, Wisconsin

■ THE MANAGEMENT OF patients with multiple myeloma has undergone changes in recent years resulting in a higher percentage and longer duration of remissions induced by chemotherapy. Prolonged maintenance therapy with oral alkylating agents has resulted in remission rates of upwards of 50%, with significant periods free of pain. In some patients with almost complete remissions there is return of blood and serum protein values to normal and return to 100% performance status for several years.

Two alkylating agents have been found to be about equally effective in myeloma: (1) cyclophosphamide [Cytoxan] and (2) melphalan [phenylalanine mustard—Alkeran]. These drugs can be given orally or, in the case of cyclophosphamide, intravenously as well. The tolerance and side effects are about the same. There is some frequency of alopecia and hemorrhagic cystitis due to cyclophosphamide and it is thought by some that melphalan causes slightly more frequent thrombocytopenia. However, both drugs are usually well tolerated as maintenance doses, and result in about an equal incidence of remissions. It is unknown whether the patient who becomes resistant to one of the alkylating agents after prolonged employment will then respond to the second alkylating agent. It would seem unlikely that this could be true.

Radiation therapy may be given to localized areas of pain, particularly to the spine, to provide palliation during or before the time that the patient is being given the chemotherapeutic agents. An adequate drug trial period in multiple myeloma may take up to three months, and chemotherapy should be continued as long as the patient shows no unfavorable progression of the disease.

The bone pain in myeloma may be particularly severe and disabling. Judicious use of oral narcotics given at regularly spaced intervals is often needed until pain relief can be achieved by chemotherapy. In addition to aspirin-codeine combinations, we often use oral levorphanol tartrate (Levo-Dromoran) [2.0 mg] or methadone hydrochloride (Dolophine) [4 mg] on a three-or-four-times-a-day basis. Addition of promethazine hydrochloride (Phenergan) [12 mg] to any of these may help in prolonging and potentiating the desired effect. Transfusions should be used only as supportive therapy usually when the hematocrit is below 20%. The dysproteinemia often results in difficulty in cross-matching and may lead to an increase incidence of reactions. It may be necessary to use type O, Rh negative blood when cross-matching is not possible.

Figure 1 represents an illustrative case of initial therapy in a young woman with multiple myeloma. The patient was quite ill with 30% plasma cells in the peripheral blood, anemia, and evidence of renal disease. At the time of admission her diagnosis was suspected from the peripheral blood examination and confirmed by the bone marrow aspiration. (The final diagnosis of multiple

Doctor Korst is Associate Professor of Medicine, University of Wisconsin Medical School.

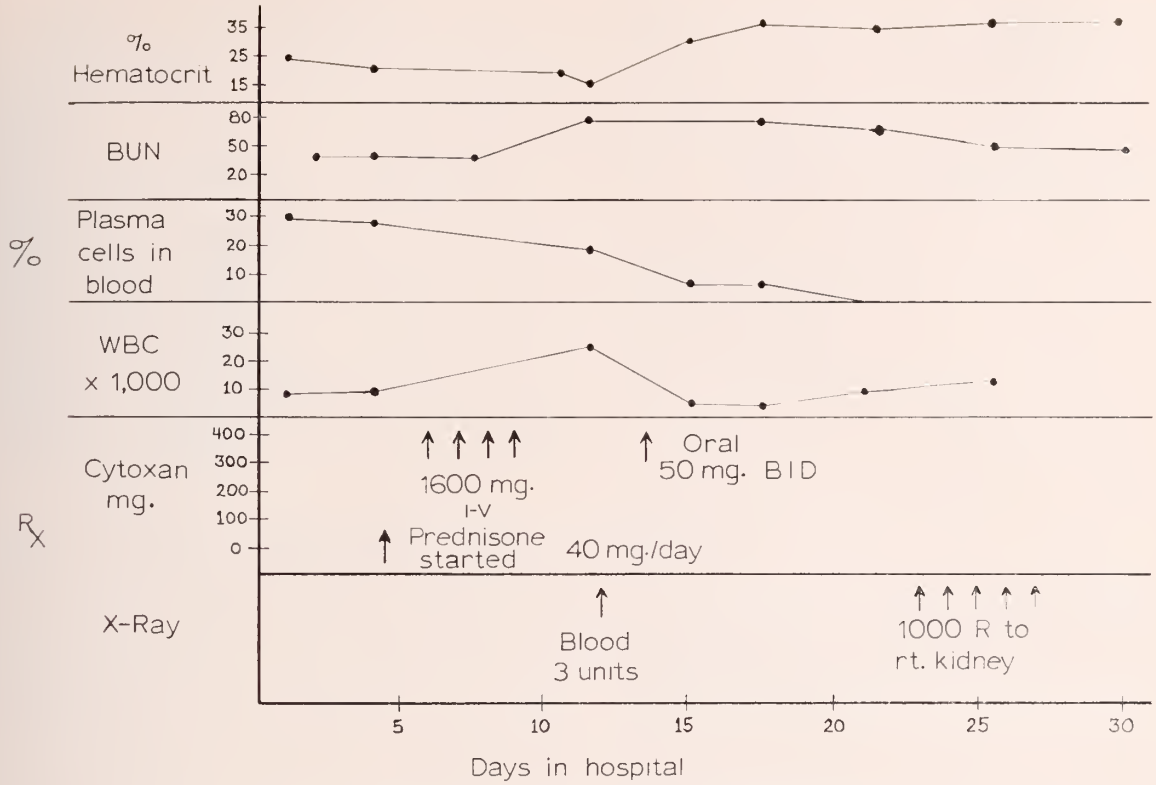

Fig. 1—Clinical course of initial therapy in multiple myeloma.

myeloma is always made by the bone marrow tissue examination.) Occasionally, one may find the bone marrow within the range of normal and only an abnormal protein pattern of monoclonal myeloma protein spike suggests the diagnosis. In these patients it is best to do a second or third bone marrow aspiration in order to confirm the diagnosis.

The patient under discussion was first given prednisone because of the rather marked bone pain, and this treatment resulted in little change. She was then given intravenous cyclophosphamide (Cytoxan) for a total of 1600 mg in four days. (The usual intravenous [IV] program with cyclophosphamide is 30 to 40 mg/kg total dose in a patient with Hodgkin's disease who has not had prior therapy or does not have bone marrow impairment.) In this patient we knew there was anemia and marked replacement of marrow by myeloma cells; therefore, the dose was 400 mg IV each day for four days (total dose 30 mg/kg). The IV infusion was given as a slow drip over a two to three hour period in order to reduce the side effects of nausea and vomiting. This initial course of therapy resulted in relief of pain. She did require three units of blood during the period of time as the hematocrit dropped from 25% to 15%. This is understandable in light of the combined depression of erythropoiesis by both the chemotherapy and the disease itself.

While she was still in the hospital, an oral maintenance dose of Cytoxan (50 mg twice a day) was begun, one week after completion of the intravenous course. Her leukocyte levels were around 3,000 to 5,000 which was considered adequate and indicative of a significant dose of the drug. The usual maintenance dose of Cytoxan is about 1.4 mg/kg per day. Most patients will tolerate this quite well. On further observation the patient continued to have a rise in BUN and it was thought that the plasma cell myeloma involvement of the kidney was not responding to the chemotherapy program. She was given 1,000 R (standard orthovoltage x-ray therapy) to one kidney, which resulted in a return to normal values of BUN and creatinine clearance 30 days after completion of the treatment. Also, the initial Cytoxan therapy had a prompt effect on her bone marrow with a disappearance of plasma cells from

the peripheral blood. Prednisone was discontinued gradually after hospital discharge. The patient has been observed for one year at intervals and at the present time is in a good remission, at work full-time, free of pain, and with normal peripheral blood values and renal function values.

We might have elected to use melphalan instead, although this drug is restricted to oral use. Patients will tolerate an initial dose of 6 mg daily for two or three weeks and then gradual reduction, depending on the blood count, to a maintenance dose which is around 2 mg daily.

Survival statistics of 165 patients with multiple myeloma who were treated for two months or more with cyclophosphamide at a mean dose of 1.4 mg/kg per day revealed that the median survival of cyclophosphamide-treated patients was significantly better than in a control myeloma group; 32 months from the time of diagnosis for the cyclophosphamide group, compared to 9.5 months for a myeloma group treated with x-ray or urethane. It would appear that myeloma is a disease responsive to an alkylating agent when given in a minimum toxicity long-range program. The experience from the survival study was based on a maintenance therapy program and it is the advice in our clinic that continuous suppression with chemotherapy is preferred.

The judicious use of intermittent local x-ray therapy to localized painful bone lesions may also benefit the patient. Radiophosphorus (P^{32}) has been used for bone pain in myeloma, but has not been as successful as the combination of alkylating agents and local x-ray therapy. Corticosteroids may be used intermittently but is not advisable for prolonged use in myeloma because of the resultant calcium depletion. We do not have any indication that the addition of corticosteroids to the long-range alkylating agent programs is beneficial. Therefore, this probably should be reserved for symptomatic benefit, or when hypercalcemia exists. Sodium fluoride given as maintenance at 1 mg/kg daily doses induces increased sclerotic appearance of bones. This form of therapy in myeloma is being investigated. Preliminary data suggest that there may not be an increase in bone strength associated with the changes in crystalline bone structure that causes the changes in x-ray appearance.

One must keep in mind in managing the patient with multiple myeloma the wide spectrum of the natural course of the disease and appreciate that some patients with multiple myeloma may get along for many months and years without apparent progression. Therefore, we do not believe that it is advisable to start patients on the chemotherapy programs unless they are symptomatic and showing definite evidence of progression of the myeloma. The progress of the disease can be adequately followed by monthly blood counts, a serum protein electrophoretic pattern done every three months, and x-ray films of the bony involvement at six-month intervals.

It has been our experience that the osseous lesions do not undergo much change, but are more apt to show no progression during the time of chemotherapy. The complication of hemorrhagic cystitis due to cyclophosphamide may be prevented by adequate hydration of the patient and by giving the patient intermittent dosage schedules, such as a single oral dose of 10 mg/kg of cyclophosphamide (Cytoxan) once each week at bedtime.

EXCESSIVE USE OF TETANUS TOXOID BOOSTERS

EDSALL, GEOFFREY; ELLIOTT, MARION W.; PEEBLES, THOMAS C.; LEVINE, LEO; and ELDRED MARY C.: *JAMA* 202:17 (Oct 2) 1967

There is strong evidence that immunization against tetanus is widely overdone.

Serum specimens were collected from 45 children, ages 4 to 17 years, and their tetanus antitoxin levels were determined. The lowest level of antibody measured in any of the children was 0.4 units or 40 times the protective threshold; the prevailing antibody levels were all 40 to 2,000 times above the minimum protective level.

In 22 patients with allergic or arthus-type reactions to tetanus toxoid, antitoxin titers were done and in 21 patients the antibody levels were above the threshold of protection.

These findings indicate that the annual toxoid boosters are not necessary. The authors recommend that routine boosters be given at 10-year intervals to those individuals who have had primary immunization including a reinforcing dose, and that emergency boosters be given no closer than one year apart.

The unnecessary frequency of booster doses of tetanus toxoid will produce a highly toxoid-sensitive population without adding to the already high protection that this immunized population has against tetanus.

W. D. James, M.D.

PRESIDENT'S PAGE

A Successful Venture with Youth

"My compliments to the Medical Society for coming forth with such a timely and imaginative program. Indeed I wish there were ways for the program to be brought to even more of our Wisconsin youth. . . . And my compliments to those teenagers who have taken the time to attend, to question, and to learn."—WARREN P. KNOWLES, Governor

"This was one of those fine educational experiences available to us for enrichment. Please do not give this up. It was thrilling, and especially boy and girl oriented."—JOHN BJORGE, Superintendent of Schools, Berlin

"It is a great satisfaction to realize that there are such organizations as the State Medical Society and the other sponsors who have such a tremendous interest in youth. Thank you for such a wonderful program."—J. DAVID CARROLL, President, Student Councils, Milwaukee Archdiocese

THE LETTERS FROM WHICH these excerpts were taken are only three of the many that were received in the weeks following the Sixth Annual Wisconsin Work Week of Health. They attest to the success of the conference and to the popularity of the subject, "Youth on a Four-Day Trip."

Credit for help in planning the program must be given to representatives of the Wisconsin Youth Council and its adviser, Mrs. Jeanne O'Connor, and to the governors of the 1968 Boys and Girls State.

For the successful execution of these plans, the Medical Society is greatly indebted to the members of its Auxiliary for their enthusiastic and energetic support. Auxiliary members in hundreds of communities contacted high school officials, helped arrange released time for students, made housing arrangements, and assisted with transportation, in many instances driving groups of teenagers to Madison in their own cars.

Because of the efficiency of our staff and the long hours they spent making the complex arrangements to cope with the unexpectedly large registration, no one who came was turned away; the program remained on schedule, and even those listening on closed circuit TV were able to join the discussions during the question and answer period.

Our Society has every reason to be proud of the Sixth Annual Wisconsin Work Week of Health. It received regional and national press coverage and projected a true image of medicine's social concern. We are deeply grateful to all of the organizations and individuals who helped make it a success.

W. D. James MD

the WISCONSIN MEDICAL JOURNAL
Published Monthly

NOVEMBER 1968
Vol. 67 No. 11

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Discerning Benevolence

AS THE GOVERNMENT contribution to medical research ranges around $1.4 billion a year—which, of course, comes out of taxpayers' pockets—greater attention should be paid to the application of voluntary contributions to private medical and health care funds. Some conscientious contributors are, in fact, examining the need for private drives with a view to better use of their donations.

According to a United Press–International report, approximately $250 million per year is donated to voluntary health fund drives. Of this amount, about $200 million goes to the ten largest national funds, including the American Cancer Society, American Heart Association, National Tuberculosis Association, National Fund (formerly the National Foundation for Infantile Paralysis), National Society for Crippled Children and Adults, and five others.

These funds spend an average of 30% of their income —or nearly $60 million—on fund-raising, publicity, and administration. Although the fact of what seems to be an extraordinarily high cost of supporting the organization and publicizing its work is not a secret, most contributors are not aware that 30¢ of each dollar they contribute to these funds does not do the work for which it was contributed. And, in all fairness, it must be added that the "Big Ten" drives are probably the most reputable. Some funds, particularly those which solicit donations by mailing unordered merchandise, take a substantially higher bite of the contributor's dollar before passing on what's left to the purpose for which it was given.

What ever the merits of private health fund drives, the narrowness of their focus and the exclusivity of their purposes leave large areas of the total health care apparatus to rock along with minimal public support. To be sure, the unsupported sectors are less dramatic and therefore less appealing to the emotions than the diseases in which the private health drives specialize. But as doctors, we recognize them as just as important as the more spectacular research problems.

For example, we know that there are not nearly enough doctors to deliver health care to the community. We know that one reason there aren't more doctors is because it costs so much to become one. We are also aware that medical education doesn't stop at the door of the medical school, but

that it must be continued through a complex of postgraduate programs for practicing physicians as well as through public education of nonmedical students.

Because we are knowledgeable about what it takes to sustain the broad, nonspectacular aspects of providing health care, we recognize the invaluable work being done by the Charitable, Educational and Scientific (CES) Foundation of the State Medical Society of Wisconsin. The funds received by the CES Foundation are used to assist needy and deserving medical students complete their education, enabling them to take their places in the ranks of doctors administering health care to the community. At the present time, funds are desperately needed for this purpose. Funds are spent to provide scientific speakers and a variety of postgraduate educational programs.

The CES Foundation sponsors lectures for nonmedical personnel regarding significant health problems; it supports education for medical and health-care careers; it subsidizes the operation of the Museum of Medical Progress and the Stovall Hall of Health at Prairie du Chien. And the CES Foundation supports research into scientific and economic problems involved in health care—often with the collaboration of other agencies and organizations.

The CES Foundation is administered by an unpaid Board of Trustees including an elected member of each county medical society. All of the funds it receives are used for the purpose for which they were donated. No money is siphoned off for fund-raising expenses. Doctors who are interested in having every cent of their contributions applied where it will do the most good will put the CES Foundation at the top of their lists of charities—both for donations in their lifetimes as well as for bequests in their wills.

The Foundation makes it easy to give in a routine, but meaningful manner. It offers a booklet of "Memorial Gift" cards, which every Wisconsin physician should keep on his desk. When the doctor wishes to pay tribute to the memory of a friend, relative or colleague, he simply detaches a card and sends it to the CES Foundation. A memorial card with an appropriate sentiment will be sent to the person named, identifying the doctor as the donor, but not revealing the amount of the gift. The doctor receives an acknowledgment of his contribution to aid him in claiming a tax deduction. Thus, the doctor honors the memory of the departed in a dignified and worthwhile way, receiving the satisfaction of knowing that his contribution will be directed by his own colleagues toward sound purposes of charitable, educational and scientific activity.

Every doctor is urged to use the CES "Memorial Gift" cards frequently and generously.—D.N.G.

New Combo

RESULTS OF INITIAL clinical tests with a combined live virus vaccine against measles, mumps and German measles (rubella), which induced protective antibodies against all three diseases following a single injection, were disclosed by a Pennsylvania virologist.

Administered in a pilot study to 28 preschool-age children, who were previously without antibodies to any of the three viruses, the experimental vaccine prompted a 100 percent response against measles and rubella and mumps antibodies in 93 percent of the children, according to Dr. Maurice R. Hilleman, of the Merck Institute for Therapeutic Research, West Point, Pennsylvania.

The virologist added that adverse reactions observed following administration of the one-shot combination vaccine were no greater than when measles vaccine was administered alone. The clinical studies, Dr. Hilleman reported, were carried out in collaboration with Drs. Joseph Stokes, Jr. and Robert E. Weibel, both of the Department of Pediatrics of the University of Pennsylvania.

The new measles vaccine, according to the virologist, is a further attenuated strain, which has exhibited a lower incidence of fever following vaccination than any live measles virus vaccine currently in use. Made from the Moraten (more attenuated Enders) virus strain developed by Dr. Hilleman and his co-workers, the new vaccine has been almost 100 percent effective in conferring immunity during extensive studies involving more than 28,000 children.

The Pennsylvania scientist also reported that follow-up studies with the mumps vaccine have indicated that adequate antibody levels with continued protection for vaccinated children have persisted for three

years without substantial decline. This provides the basis he said for belief that the immunity will be long-lasting, probably lifelong.

Although broad-scale clinical trials must be carried out with the one-shot combination vaccine before it can be considered for general use, Dr. Hilleman stated that the findings, though preliminary, demonstrated the feasibility and utility of the combined vaccine approach for routine application.

In addition to enhancing the possible eradication of the three diseases in the United States, Dr. Hilleman observed that the combination vaccine would be of particular value in developing nations where acute shortages of medical personnel exist.

The Enigma of Exophthalmos

THIS ISSUE of the *Wisconsin Medical Journal* carries a case report, "Ophthalmopathy with Hypothyroidism," presented by George W. Dean, M.D., which moves us to this special comment.

It serves to remind us that the problem of exophthalmos still is a clinical entity, and that our understanding of its pathophysiology remains lamentably inadequate.

The association between thyroid disease and exophthalmos was pointed out many years ago by men like Graves, whose name became synonymous with exophthalmic goiter. The clinical experience of the endemic goiter years firmly established this association but failed to provide us with answers. Even our modern approaches to the overall problem have been unable to define a specific cause and effect relationship.

Fortunately, both the incidence and clinical importance of serious exophthalmos have markedly decreased in the past thirty years. Reports of the "malignant" type, requiring orbital decompression, have become rare indeed. But the fact remains, the problem of exophthalmos has not vanished from the clinical scene. It remains as a challenging enigma to medical research.—LESLIE G. KINDSCHI, M.D., Monroe

* * *

ABOUT 35 MILLION persons served in U. S. Armed Forces during the nation's wars. Nearly one million gave their lives and additional millions were wounded.

The Honorable Oscar Rennebohm

FEW MEN IN WISCONSIN history have so exemplified the currently popular "We Like It Here" theme as did Oscar Rennebohm. Almost his entire adult life was a demonstration of his faith and pride in the State of Wisconsin and its people. In business, in education, and in government he was himself a great citizen, giving of unusual ability and fine service, receiving confidence well-merited in return.

The medical profession has reason to look upon his loss with special sadness. His contributions to medicine, pharmacy, and related fields were many . . . and often unknown except to very few. He took more than the usual interest as a director in the State Medical Society's Charitable, Educational and Scientific Foundation. In a measure more than anyone knows we, the people of Wisconsin, "like it here" because of what he was and what he did. Thank you, Mr. Rennebohm.

THE MEDICAL STUDENT FORUM

Devoted to the expressions of the medical students at the University of Wisconsin and Marquette medical schools through association with the Student American Medical Association. A feature originated by the State Medical Society of Wisconsin to stimulate closer relationships with the physicians of tomorrow. This space is offered monthly to both schools on an alternating basis, with copy deadline the first of the month preceding the month of publication. Statements and opinions contained herein are those of the students.

NOVEMBER 1968

MEDICAL CARE AND THE POOR —MIGRANT WORKERS IN WISCONSIN

DURING THE SUMMER of 1968, I was one of 26 medical students who with 30 members of the faculty of the University of Wisconsin Medical School participated in clinics for the migrant workers of central Wisconsin. This experience offered me an insight as to what it is like to be poor and in need of medical care.

The plight of the migrant workers is reflected in a report by the Governor's Committee on the Migrant Worker. It states that in central Wisconsin the migrants stay an average of 45 days and take away about $200 per family—about $4.40 per day. Their migration to the north in summer is the result of at least two factors: school students flood the market and Mexican citizens daily cross the U. S. border into southern Texas where companies can hire them for less because Mexicans have neither the high cost of living nor the military obligation as Americans do.

However, this migration is hardly an answer to their economic plight: until 1968 the standard wage for field work was 50¢ an hour.

But poverty is just one of the migrants' problems. Many do not speak English. They're unaccustomed to our complex system of appointments, multiple forms, prescriptions to fill and take. They often become discouraged and accept their illness passively. And, they are a proud people who don't readily admit they don't understand things.

Because of the migrants' basic ignorance of health and disease, they often are unable to distinguish between the less significant conditions and those requiring prompt medical treatment. This is a frustrating situation in the doctor-patient relationship.

The sheer number of migrants coming into an area at peak season is another major problem. Medical facilities, already taxed by tourists, are literally swamped. Several communities have established local clinics for the migrants and this is where we medical students were introduced to the problem. The University of Wisconsin Student Health Organization arranged the medical school participation. Funds were provided by the school and the local clinics for five full-time medical students.

At the Wautoma Migrant Clinic where I worked, we had a different group of doctors at each session, including the medical director from Wautoma, six volunteer doctors from Oshkosh, and 30 volunteer doctors from the University. Although we had highly competent doctors, the continuity of patient contact was lacking. A person returning to the clinic seldom saw the same doctor. The medical students helped to fill this gap. We followed particular families for the entire summer. We handled the patients' history-taking, physical exams, and lab work before the doctors saw them. In spite of the language and cultural differences our repeated contacts with the migrants allowed us to gain their confidence and trust. Because of the initial work-up and associations, we became a source of reference for the different doctors.

After the doctors had seen the patients,we saw them again to explain the administration of medications and double-checked to make sure they understood their illness and treatment.

For those who needed more extensive medical care than our simple clinic could provide, we often took them to the Welfare Department to help them obtain aid for which they were eligible. We also arranged for hospital beds and provided transportation.

As the summer progressed, we gradually saw our role as that of a "patient advocate"—a person who knows his way around medically and can get the most for his "client" from the medical care system. He also knows the welfare system well enough to take advantage of any available resources. Finally, he takes the time to educate the person medically and helps him solve any personal problems that may arise during his illness.

I think the concept of the "patient advocate" is one that should be investigated further, for it is something that can help fill a large gap in modern medicine. Not only is it useful in arranging for total medical care for low-income, under-educated people but also it may be a means of providing direction to middle-class people who find themselves floundering in the attempt to pilot their course of medical management through the many subspecialties we have today. The concept of the "patient advocate" is also a way that first and second year medical students can be introduced to medicine and at the same time perform a very useful function.—PAUL WERTSCH, Med. III, President of the UW Student Health Organization, Madison

The Gift Book . . . By VIRGINIA HOLTZ, Madison, Wisconsin

THE GIFT BOOK has been an element of the holiday seasons for as long as civilization has encompassed both man's ability to read and the availability of the written or printed book. In this modern day of advanced forms of communication, the printing, buying and selling of books continues at an all-time high. As information scientists search for more perfect forms of communication, the traditional book form serves many of today's needs—aesthetic, scientific, and commonplace.

In keeping with this lengthy tradition, you will find annotated below some of the more interesting titles which have come into the Middleton Medical Library of the University of Wisconsin Medical Center this past year, and a few from earlier years, which would seem to be likely candidates for a gift list. These are not medical texts or monographs on new developments in the health fields which may be found in abundance in the book review columns of the WISCONSIN MEDICAL JOURNAL, the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, and some of the specialty journals. (For a quick survey of titles published in recent years, scan the indexes under "Bookshelf-Book Reviews" in *WMJ* and "Book Forum" in *JAMA*.) The medical book dealers also sponsor an annual selected list of medical books in print.

These titles are just a sample of that genre of book which is intended rather for the leisure hour away from the pressing, everyday grind of things that MUST be done. They may be picked up at will, though some are very difficult to put down, once started.

If popularity awards were being given, first honors would doubtless go to James D. Watson's *The Double Helix*. This fast-paced and sometimes startlingly frank account of one man's view of the discovery of the structure of DNA, is in its own way a real thriller. The introduction by Sir Lawrence Bragg warns you that the chapters to follow are clearly a younger Watson's undiluted view of his contemporaries and his world during the race for the molecule. Watson does not disappoint you. Whatever your opinions of the people and events during and after the reading, the book has about it a literary style and nonstop quality that make it well worth the effort.

Another timely subject is covered in *The Transplanted Heart*. Author Peter Hawthorn attempts to capture the human drama behind Dr. Christiaan Barnard's historic operation rather than report technical detail. Chapters are devoted to the main characters; the donor's family, the recipients, the Barnard brothers and their research and surgical teams, as well as the social and scientific setting in which the action took place. Hawthorn avoids the trap of putting words into the mouths of his principal characters, using instead quotations from the many interviews. Who could improve on Christiaan Barnard's, "My moment of truth—the moment when the enormity of it all really hit me—was just after I had taken out Washkansky's heart. I looked down and saw this empty space . . . the realization that there was a man lying in front of me without a heart but still alive was, I think, the most awe inspiring moment of all."?

If you find the rugged outdoor biography more to your liking there is Dudley Copland's *Livingstone of the Arctic*. Leslie Livingstone "firmly believed that his family was related to the famous explorer," though the written records necessary to confirm this theory did not exist. He came of early pioneer stock which migrated from Scotland to settle in Upper Canada. The young Livingstone entered Queen's University in 1911, with every intention of becoming a mining engineer, but after two years he shifted to medicine. Though he spent five years in study he never wrote his finals and so did not receive his degree at that time. In 1922 his fortunes were influenced by the chain of events which were to lead him to spend a good deal of the rest of his life above the Arctic Circle. His efforts to assist the Eskimos did not end with medical care, but encompassed such diverse projects as an attempt to breed better sled dogs, an experimental farm and dairy herd, and an Eiderdown collection program. In the meanwhile he had to deal with rabid sled dogs, long trecks over uncharted territory, and the many medical problems peculiar to frontier practice.

Clark's History of Wisconsin Medical School On Preferred List

A Journey to Paris in the Year 1698 by Martin Lister edited with Annotations, Life of Lister, and a Lister Bibliography, by Raymond Phineas Stearns, is a facsimile edition of the 1698 travel biography. Lister spent some months in Paris as physician to an English diplomatic delegation. Since it was a remarkably healthy delegation and Dr. Lister was totally uninterested in politics, the good physician spent his time seeing, in Paris, those things which did interest him: the gardens, the libraries, collections of "natural curiosities," factories, hospitals, and a host of other sights. He wrote the Journey, as he puts it, "to satisfie my own Curiosity," and "to spare the often telling my Tale at my return." For a doctor's eye view of Paris in 1698, we recommend *A Journey*.

For more recent history there is, of course, the book no Wisconsin graduate should be without, Dr. Paul F. Clark's, *The University of Wisconsin Medical School, a Chronicle, 1848–1948*. As defined by historians Curti and Carstensen, Dr. Clark himself

Miss Holtz is Associate Librarian and Director of the Medical Library Service of Middleton Medical Library, University of Wisconsin Medical Center.

is indeed a "primary source" of information concerning the history of this medical school. It is impossible to describe a book such as this. To each man reading it, it will mean something slightly different, according to his years, his specialties, and his tenure at the University. This is something each person must discover for himself.

Book on Taxes is Popular Reading

René Dubos, faculty member at Rockefeller University since 1927 and perhaps best known as an editor of the JOURNAL OF EXPERIMENTAL MEDICINE and author of *Bacterial and Mycotic Infections of Man* and other titles, has issued as his latest work a book entitled *Man, Medicine, and Environment.* Starting with Darwin and the importance of his theories in establishing the hierarchical structure of "the living world," Dubos methodically pursues his examination of man's nature and his biomedical responsibilities to the world and its inhabitants. Based on his thesis that it is mankind's responsibility ". . . not only to treat its disease but also to protect its health against the dangers created by technical innovations," the book covers his views on many of today's problems, from smog to overpopulation, from the lasting affects of deprivation to the environmental stress of affluent countries. As valuable, perhaps, for the thoughtful questions it raises as for the answers it proposes, with which you may or may not agree, the book is a serious essay on man's responsibility to himself and his world.

Another excellent selection for students of mankind is *Human Variation and Origins, an Introduction to Human Biology and Evolution.* Two University of Wisconsin Professors of Anthropology, W. S. Laughlin and R. H. Osborne, have edited this selection of *Readings from* SCIENTIFIC AMERICAN and prepared introductory paragraphs. The book is concerned with the variability of the human species which at the same time maintains its identity as a single species. Covering the gamut from Darwin to Crick and including works by such local authors as Dr. James Crow and the Drs. Harlow, this is a book which can be taken in large or small doses by those with a general interest in man as an adaptable animal.

For those with a touch of Sherlock in their makeup there are at least three new titles and several older works still in print. Jürgen Thorwald's *Die Stunde der Detektive* has been translated and is now available under the title *Crime and Science, the New Frontier in Criminology,* translated by Richard and Clara Winston. It is divided into two sections: "I. At the Limits of Detectability; Forensic Serology" and "II. Clues in the Dust: Forensic Chemistry and Biology," each made up of case histories of crimes in various countries and the scientific methods used to solve them. If you like your history spiced with drama and excitement, this volume, by the author of *The Century of the Detective* should be your cup of tea.

The events which form the basis for the book *Wreath on the Crown; The Story of Sarah Jacob the Welsh Fasting Girl* took place just about a century ago. Retold by John Cule from some earlier studies of the case, this slim volume covers the history of Sarah's remarkable fast, the involvement of the medical community, the two "watches" set over the Welsh Fasting Girl and the trial following the second "watch." The courts, of course, decide the case, but that won't stop the reader from forming his own opinions as to who the guilty parties are.

Where Death Delights, by Marshall Houts, chronicles the rise of forensic pathology in New York under the aegis of Milton Helpern. While it does not compare with some of its British predecessors in the field, Sir Sydney Smith's *Mostly Murder* and Molly Lefebure's *Evidence for the Crown,* due to a rather constant whine in the author's typewriter, it does contain some interesting factual material and some fascinating case studies.

For those with a more practical bent, we are willing to bet that MEDICAL ECONOMICS *Tax Savings Guide for Physicians* is the most readable book written on that subject. Lest you think this book not appropriate for the holiday season, try this quote and see if you change your mind. According to William Allen Richardson, Editor in Chief of Medical Economics Book Division Inc., "The difference between skillful and inept tax management can well

NATIONAL LIBRARY OF MEDICINE PROVIDES "TELECONFERENCE" SPEAKERS

On January 21 and March 18, Telephone/Radio Conferences presented as part of the Medical Library Seminars, will feature lectures from the National Library of Medicine. The content of their talks is of importance to everyone dealing with biomedical literature.

On January 21, Norman P. Shumway, M.D., Chief of the Medical Subject Headings Section, Bibliographical Services, will present a program on the INDEX MEDICUS and MESH, companion keys to the world's biomedical literature. On March 18, Clifford Bachrach, M.D., Chief, Bibliographic Services Division, will discuss the MEDLARS Demand Search Service, National Library of Medicine's computer-based biomedical literature search system.

The programs will begin at 2:00 P.M. and each will be followed by a question and answer period during which the speaker for the day will be available for comment.

Anyone interested in taking part in either or both of these sessions may obtain further information by contacting Mrs. Ann Johnston, Coordinator Telephone/Radio Conferences, Room 302, 333 N. Randall Ave., Madison, Wis. 53706.

affect your total income tax bill by as much as 20 per cent." Now in its second printing (first issued in 1965) the 199 pages are devoted to such topics as "Must you report it as income?," "Extraordinary savings on 'ordinary' income," "Nail down your convention and education deductions," "Your medical expenses may be larger than you think," "After an audit: Pay up or fight?," "Relieve that quarterly tax ache," and many others.

For something in a lighter vein, try Richard Armour's *It All Started with Hippocrates: A Mercifully Brief History of Medicine.* "The germ," as he says, of the book was contained in a similarly titled article published in the *JAMA* and covers the story of medicine from shortly before the dawn of history, "about 3:00 A.M., when the first Stone Age doctor was roused from his bed to attend a patient who thought he was dying" to medicine today.

Rose Franken, author of the Claudia and David series of novels and others has been to the hospital and lived to write again. The result, *You're Well Out of a Hospital,* is another patient's eye view of life in today's depersonalizing institutions. Her barbs are aimed mainly at the hospital and nursing staff. While meant humorously, the cry of the bewildered patient, sensitive, susceptible, and uncertain occasionally finds its way through the laughter to plead again the case of the sick.

These few titles illustrate only a small portion of the publishers' output for the year. Not only are there other titles in these categories but also whole groups of health-related literature not represented here. All of the books mentioned in this article are available on loan from the Middleton Medical Library and all should be obtainable through bookstores, from medical book dealers, or from the publishers. When making out your gift lists don't forget the wealth of thought, knowledge, humor, history, and inspiration that may be found between the covers of books.

1305 Linden Drive (53706).

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MIDWEST REGIONAL MEDICAL LIBRARY NAMED

The John Crerar Library, Chicago, has been designated the Midwest Regional Medical Library by the National Library of Medicine, National Institutes of Health. It will serve medical practitioners, researchers, and educators throughout the five-state area of Illinois, Indiana, Iowa, Minnesota, and Wisconsin. Announcement of a $150,000 grant for the new Regional Medical Library was made jointly by Martin M. Cummings, M.D., Director, National Library of Medicine, and Oliver W. Tuthill, President of the Crerar Library.

The grant, made under authority of the Medical Library Assistance Act of 1965 (Public Law 89-291), will allow the Crerar Library to serve as part of a proposed national medical library network. This network is designed to make information services for activities related to practice, education, and research available to health professionals in all areas of the country.

The Middleton Medical Library at the University of Wisconsin Medical Center is part of the library network.

An advisory group known as the Council of the Midwest Regional Health Science Library and Cooperative Information Services was organized in Chicago two years ago as a preliminary step in the establishment of a regional medical library. It had its second annual meeting Oct. 25 in the American Hospital Association headquarters in Chicago. Dr. V. S. Falk of Edgerton, medical editor of the WISCONSIN MEDICAL JOURNAL, was reelected vice-chairman of the Executive Committee at this meeting. The Council is comprised of librarians and health professionals from the five-state area who review current projects of the regional library and make recommendations for new programs.

The Midwest Regional Medical Library is the fourth of a proposed network of nine or ten to be operational by 1970.

WISCONSIN MEDICAL JOURNAL
VOL. 67, NO. 11 NOVEMBER 1968

Medical
GREEN SHEET
NEWS OF SOCIO-ECONOMIC MEDICINE

State Medical Society Foundation Grows; Supports Wide Variety of Worthy Projects

Total contributions to the Charitable, Educational and Scientific Foundation, Inc. of the State Medical Society of Wisconsin have passed the $600,000 figure.

These funds have been devoted to projects of charity, professional and public health education, and scientific and socio-economic research.

Contributions for 1968 to date were over $46,000, largest for such a period since the CES Foundation was established by the State Medical Society in 1955.

Interest, Projects Expand

During its 13 years of operation, the CES Foundation has grown in breadth of interest as well as in volume of financial contributions to worthy projects.

In the early years, the Foundation's activity was largely confined to support of medical student loans. Such loans continue to be a major program of the Foundation, with more than $175,000 currently on loan to 144 students.

Scientific studies and research soon became a substantial interest of the Foundation especially in areas for which funds are not otherwise available.

One of the first was a hearing loss project made possible by a grant from the Nelson Muffler Corporation of Stoughton, Wis. Its goal was to "determine" if there is any associated or accompanying hearing loss in systemic disease (diabetes, coronary heart disease, etc.) which is not present in the healthy individual of the same age and sex. This study concluded in 1962 with conclusions as to the effect of diabetes mellitus on hearing loss in industry.

More recently a study of the cardiac worker in industry was enhanced by CES Foundation participation. Since this project is still in progress, final results are not available.

Postgraduate education of physicians and continuing education of those allied to the medical field is another area to which the CES Foundation has turned its efforts.

THE SYMBOL of the Charitable, Educational and Scientific Foundation of the State Medical Society is shown at the left . . . the serpent of Aesculapius, entwining a staff, and the dictum of Hippocrates: "Life is short, art is long, experience is difficult."

Teaching programs for physicians, implemented through the Foundation, now involve nearly 2,000 MDs annually. This is possible through the Speakers Service to county medical societies, regional "in-depth" programs, and special conferences and lectures on various medical subjects.

Scientific Education

The Foundation has made several significant contributions to scientific education through conferences on internship programs in Wisconsin, a statewide conference on the medical aspects of mental retardation, prematurity and maternal mortality institutes and conferences on the newborn, stroke, and athletic injuries.

Early in the CES Foundation activity it became clear that it could perform a valuable service to physicians and the public by directing attention to certain socio-economic problems related to health.

The first moves in this direction were made in 1959 when CES Foundation grants were made for studies of "Health Insurance for the Aged" and "Costs of Medical Care in the Hospital." These studies contributed measurably to the direction that medically-sponsored programs in these fields have taken since that date.

(Continued on page 579)

Funds Still in Short Supply for Loans to Medical Students

FACT: The average cost of four years of medical education is $10,152 for single students and $19,888 for married students.

FACT: Ninety-nine percent of all medical students work some or all of the time while in medical school. Deans of schools recommend no more than 10 hours per week of outside work . . . yet, the average student works 15 hours weekly, and ten percent work 40 hours or more weekly.

FACT: The median amount of loan received by a medical student during four years of schooling is currently $3,000. Some borrow as much as $25,000. The average loan granted to a CES Foundation recipient is $1,600. Most students report they would borrow from $5,000 to $6,000 more than they now do if it were available on reasonable terms.

These are the cold, hard facts of the financial needs of the modern medical student.

These are the facts upon which the Medical Student Loan Fund of the CES Foundation of the State Medical Society is built.

Loans Help 223

Since 1951, when the fund was established, more than $266,000 has been loaned to 223 medical students. Currently, the Foundation is providing loan assistance to 144 students totaling more than $175,000.

Typical of the comments of the CES Foundation borrowers is this report from a third-year resident with five children:

"My total indebtedness at this time, from medical school through internship and my third-year residency training program in neurosurgery is approximately $22,000. Of this total, the Society has loaned me $3,000. There is no doubt whatsoever that without financial support from the State Medical Society my medical education would have been a severe hardship for myself and family."

It is estimated that nearly 50 percent of the students at Marquette or University of Wisconsin medical schools are, at some point in their schooling, so financially embarrassed as to jeopardize their continued education.

Loan Interest Small

CES Foundation loans are made, generally, in amounts not in excess of $1,000 per year for a total of three years. No interest is assessed until the student is licensed and has completed military-medical service. Interest then applies on a graduating basis from two percent the first year to four percent the third year and thereafter.

All loans are secured by a $2,000 life insurance policy or the amount of the loan, whichever is greater.

A student receiving a loan places himself under no obligation to practice in a predetermined location.

Applicants for CES Foundation medical student loans must be registered students in an approved medical school. Under current financial limitations, they must be residents of Wisconsin attending either Marquette School of Medicine or the University of Wisconsin Medical School.

The demand for medical student loans far exceeds the ability of the CES Foundation to provide assistance. It is estimated that at least another $250,000 would be loaned almost immediately if it were available.

Not infrequently students report that the ability to borrow is a "critical factor" in choosing to continue in medical education or abandon the effort.

Surprisingly, it is often the availability of relatively small sums that makes the difference.

Says one medical graduate, now in military service:

"During my second year of medical school I borrowed $500 from the program . . . your aid came to me at a time when no other funds were currently available and I am very grateful."

Another physician, now in practice, reported: "Without this program, I would not have been able to complete my medical school training."

Dr. W. D. Stovall, Madison, president of the Foundation, states: "The student loan fund of the Foundation is still far short of its ultimate goal. Through it, physicians and others can make a singular contribution to those of their brothers for whom finances constitute a special hazard in the pursuit of professional knowledge."

THE AESCULAPIAN STAFF Collection of the CES Foundation is shown behind Dr. C. H. Peters, Bismarck, president of the North Dakota State Medical Association, and Dr. Amos Gilsdorf, Dickinson, N. D., past president of the association. Part of the 25-staff collection was displayed at a recent meeting of physicians in Bismarck. The staffs, made of hammered brass, inlaid mother-of-pearl, rich woods, treasured coins, colorful buttons, common nails, tile, and needlepoint are usually displayed at the headquarters of the State Medical Society in Madison.

The story of this collecion, including an explanation of the difference between the Aesculapian staff and the caduceus is available from the Foundation office.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others.

Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1968 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thayer, Director of Socio-Economic Medicine.

For Loan to Medical Students: Seven microscopes in excellent working condition. No charge. Contact the CES Foundation of the State Medical Society, Box 1109, Madison, Wis.

That's right! A microscope loan program for deserving medical students. Another CES Foundation project.

FOUNDATION

(Continued from page 577)

In 1963, a Foundation grant made possible evaluation of all types of teaching aids available to the state's school system and publication of a highly valuable guide for teachers listing acceptable health educational materials.

A significant contribution in the socio-economic area of health was made by the CES Foundation in 1962–63 when it surveyed the health problems of the residents of Menominee County and made recommendations leading to joint private–governmental efforts at improving the health care outlook of the Indians there.

One of the most extensive, on-going health educational efforts in Wisconsin has been made possible by the CES Foundation in the development of the Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien.

The Museum reaches out to the public not only with the story of medicine's past but also with illustration and interpretation of its rapidly changing present.

A message of medical and scientific achievement is presented directly to more than 24,000 visitors annually, and through publicity, traveling exhibits, and speakers to many thousands more.

In all, the CES Foundation's activities encompass the wide scientific, educational, charitable and social commitments of its chief sponsors—the members of the State Medical Society of Wisconsin—carried out with the realization that no profession is an island unto itself.

Outline of Loan Funds Offered by Medical Society Foundation

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin has loan funds available to Wisconsin students in pharmacy, dentistry, nursing, and medicine. These loan funds have been donated by individual physicians, county medical societies, personal memorials, and from other sources.

All loan applicants are required to be enrolled in an accredited school, and applications must be filed with the dean or director of the school for approval.

The funds and their residency requirements are set down below.

Fund	*For education in:*	*Applicant must be resident of*
CESF General Loan Fund	Medicine	Wisconsin
Dane County Health Careers Loan Fund	Medicine Dentistry Pharmacy Nursing	Dane County
Grant County Health Careers Loan Fund	Medicine Dentistry Pharmacy Nursing	Grant County
Outagamie County Health Careers Loan Fund	Medicine Dentistry Pharmacy Nursing	Outagamie County
Trempealeau County Health Careers Fund	Medicine Dentistry Pharmacy Nursing	Trempealeau County
Marinette County Health Careers Loan Fund	Medicine Nursing	Marinette County
Menominee Educational Fund	Nursing and Similar Health Fields	Menominee County
Beverly Schuster Memorial Fund	Nursing or Paramedical	Racine County
Popp Student Loan Fund (Albert Popp, MD, Milwaukee)	Medicine	No residency qualifications. Marquette Medical School students receive priority.
Jefferson County Nursing Fund	Nursing	Jefferson County
Danforth Medical Student Loan Fund (Mrs. Quincy H. Danforth, Oshkosh)	Medicine	Wisconsin

THE CHRISTMAS CARD of the CES Foundation is fast becoming an established custom. This year the card features an original painting of "Christmas Dinner at the Surgeons Quarters" at Fort Winnebago near Portage. The Surgeons Quarters stand today, nearly as they did 150 years ago, restored and operated by the Wisconsin Society, Daughters of the American Revolution. Purchase of the 1968 holiday greeting benefits the CES Foundation. Orders may be placed with the Foundation, Box 1109, Madison, Wis.

Begin Research on "Cardiac in Industry"

Special problems of the cardiac patient in industry have been the object of intensified research under grants from the CES Foundation during 1967–68.

Directed by George A. Hellmuth, MD, and Elston L. Belknap, MD, both of the Marquette School of Medicine, Milwaukee, the project was designed to focus research on medical evaluation, placement, and re-employment of the cardiac in industry.

Among the goals of the study, still going on, are:

1. Review of employment policies regarding the cardiac case in industry, primarily in Wisconsin, but with application to other states as well.
2. Further study of medicolegal attitudes of attorneys toward Workmen's Compensation in Wisconsin as it relates especially to cardiac disabilities.
3. Completion of studies initiated earlier as to attitudes of industrial supervisors toward cardiac workers.
4. Determination as to the usefulness of a cardiac work classification unit in rehabilitating cardiac patients and returning them to employment.
5. Preparation of lay information on work and heart disease in industry.

Early in 1967 the CES Foundation undertook a program to support this research project. Among the contributors, in addition to the CES Foundation, were:

Northern Engraving Company, Sparta
Motor Castings Foundation, Inc., West Allis
Waukesha Motor Co., Waukesha
Kohler Co., Kohler
Arps Corporation, New Holstein
Sola Basic Foundation, Milwaukee
Scott Paper Company, Marinette

As a result of these contributions with the assistance of the CES Foundation, Doctor Hellmuth and his associates have extended their research and educational efforts in a number of ways.

Several "papers" and reports have been prepared and distributed:

. . . "Cardiac Criteria for Workmen's Compensation Act in Wisconsin," a presentation of model rules of practice for cardiac workmen's compensation claims, published in the *Wisconsin Medical Journal*, June 1967.

. . . "Workmen's Compensation and the Cardiac—The Medical Viewpoint," reporting on various studies of workmen's compensation for cardiac disease and the physician's role in rehabilitation of the cardiac worker, published in the *Journal of Industrial Medicine and Surgery* for September 1967.

. . . "Comprehensive Evaluation of Heart Cases under Workmen's Compensation," discussing the growth of cardiac disease in the working population and problems presented for both employes and employers, published in the November–December 1967 issue of the *Journal of Rehabilitation*.

A survey of attorney attitudes on the medicolegal aspects of cardiac cases under the Workmen's Compensation Act of Wisconsin was conducted by Doctors Hellmuth and Belknap in cooperation with the Marquette University Law School. The results of this survey are currently being formalized in a report soon to be available.

Another report entitled "Employment in Industry," is in preparation. It will deal with a survey of Wisconsin manufacturing firms on their hiring policies in regard to cardiacs. The survey results indicate that most firms are reluctant to hire cardiac applicants for a number of physical and economic reasons.

Public Informed

During the past two years, under this project, ten articles have been prepared by Dr. Hellmuth for nonmedical consumption. Seven of these have dealt with heart attack prevention and three with physical fitness. They were distributed to 250 newspapers and magazines in Wisconsin.

The cardiac study project is still in progress, and the Foundation continues to seek additional support for it from industry, physicians, and others.

Foundation Charity Begins at Home

Every practicing physician recognizes the unquestionable need for timely aid to the kin of his profession who face unusual financial hardship.

As an example, a physician, age 71, finds his personal resources diminished to the point that he is almost totally dependent upon outside support. He has no immediate family and any relatives are remote. The CES Foundation is supplementing his small income to help him maintain a minimal standard of living.

In still another situation the CES Foundation is assisting a physician who has practiced more than 50 years and whose physical condition now prohibits the continuation of his practice and thus his source of income. Again, the CES Foundation provides modest but vital assistance.

Personal hardship strikes at physicians and their families as well as others. Through the CES Foundation there is an opportunity for professional persons to assist their colleagues who suffer adversity.

Old Fort Crawford and Hall of Health Growing as Medical History Attractions

One of the great educational and cultural institutions of the Midwest is in the making at Prairie du Chien.

It is the Museum of Medical Progress and the Stovall Hall of Health . . . begun in 1957 as the culmination of three decades of planning by the State Medical Society of Wisconsin.

In establishing the Museum at the site of historic Fort Crawford Military Hospital, the CES Foundation is doing far more than paying tribute to Dr. William Beaumont whose work there laid the foundation for knowledge of the digestive process.

"Living" Exhibit Concept

It is building an institution through which the medical profession can launch an entirely new educational approach to the cause of disease, early recognition, diagnosis and treatment; medicine's efforts to control and cure disease; the nature of medical and health care in its broadest aspects; and why the bond of confidence and trust between physician and patient is so essential to ethical and effective health care.

To carry out this concept, the Foundation has restored a section of the old military hospital of Fort Crawford, developed an administration building and curator's workshop, and constructed and equipped a "Hall of Health."

Discarding the "antique shop" approach, the effort has been to create a series of "living," changing exhibits, dioramas, and motion pictures.

The restored Fort Crawford hospital features Doctor Beaumont memorabilia, dioramas of "great moments" in medicine, pioneer physicians, restored physician, dental and pharmacy offices, and military medicine.

Stovall Hall of Health features the "transparent twins" and their story of body structure and function, exhibits on hearing, tuberculosis, nursing, camping for health, hobbies for health, and quackery.

Throughout the visitor season from April 15 to November 1, a wide variety of exhibits are brought to the Museum from around the nation. They range in interest from athletics and aging to space medicine.

This past season more than 24,000 persons visited the CES Foundation-operated Museum site. The future promises far greater attendance in the area, with the U. S. Division of Forests and Parks predicting more than 250,000 visitors a year to Prairie du Chien historical and archeologic attractions.

National Historic Site

Adding to the interest has been the designation of the Fort Crawford hospital as a "national historic site."

Many voluntary health organizations, businesses with a concern for health, and specialty groups within medicine are contributing ideas, funds, artifacts and exhibits to the Foundation to implement the educational goals of the Museum.

With this kind of support, the Museum is rapidly expanding its ability to portray the physician and others on the health "team" in the proper framework with scientific progress, medical practice, and social development.

Through the CES Foundation, another Wisconsin first has become a reality . . . the Museum of Medical Progress . . . first of its kind in the nation.

WISCONSIN DOCTORS SUPPORT HOPE

Project HOPE, the worldwide ship-based program for medical teaching–healing is one of the special projects to which the CES Foundation of the State Medical Society has urged priority.

Wisconsin physicians have been encouraged to earmark contributions to the CES Foundation for HOPE. In 1968, such gifts totaled $1,125.

HOPE has trained more than 4,000 medical personnel in developing nations as well as continuing educational exchange programs in medicine, dentistry, nursing, public health, medical technology, pharmacy, and other paramedical specialties. Its president is William B. Walsh, MD of Washington, D.C.

Scientific Teaching Is Major Part of CES Foundation

The complex science and art that is medicine poses a special challenge to the CES Foundation of the State Medical Society of Wisconsin.

The scientific education of the physician, the task of helping the MD maintain his skills at a level that keeps pace with scientific progress is a major activity of the Foundation.

With the exception of the teaching programs directly associated with the Annual Meeting of the State Medical Society, almost all of its professional educational effort is now being developed through the Foundation.

In 1967–68, the CES Foundation was responsible for a wide variety of such activities:

Four "in-depth" programs from December 1967 through March 1968 attracted a physician attendance of nearly 225. These programs dealt with clinical immunology and allergy, marriage "on the rocks," hypertension, and anticoagulants.

Twenty physician speakers were provided to ten county medical societies and one Councilor District meeting during the first six months of 1968. A total of 694 physicians participated.

The Foundation was assisted in these projects in 1967–68 by support from the Wisconsin Division of Health, the University of Wisconsin and Marquette medical schools, and Merck, Sharp and Dohme Postgraduate Program.

Between November 1967 and April 1968, the Foundation developed a series of five prematurity institutes. These were held at Neenah, Tomahawk, Waukesha, Dodgeville, and Superior with nearly 100 physicians and nurses in attendance.

It has been the effort of the Foundation to be especially helpful to the smaller medical societies and those more remote geographically. Even though the numbers of physicians reached may be relatively small, it is felt that the impact on the health of the people in Wisconsin will be great as these programs continue.

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MEMORIAL GIFTS to the Charitable, Educational and Scientific Foundation of the State Medical Society are used by many as a means of paying tribute to the memory of a respected friend, relative, or colleague. When such a gift is received, the CES Foundation sends a memorial card to whomever is named by the donor. While the donor is identified, the amount of the gift is not. Each donor receives a receipt for tax purposes. Booklets containing a supply of the memorial gift cards shown above are available upon request to the Foundation office.

CASH AND HOBBIES HELP FOUNDATION

Financial support of the State Medical Society's CES Foundation is achieved in many ways.

First, all members of the State Medical Society are solicited each year at the time of their medical society dues billing. They are asked annually for voluntary contributions to the Foundation, with a suggested contribution of $10 or more as established by the House of Delegates.

Second, many physicians make additional yearly donations.

Third, physicians and others outside the profession contribute through a will, a commemorative or memorial gift, or by a carefully directed and earmarked offering.

Fourth, business, industry, other foundations, and nonmedical individuals offer grants or similar contributions for either general or specific purposes within the scope of the CES Foundation where their interests parallel those of the Foundation.

Fifth, gifts frequently take the form of cash, life insurance benefits, securities, land, books, instruments, stamps, coins or other hobby collections, works of art, and other artifacts.

Gifts from any source or of any kind may be "unrestricted," permitting the Trustees of the Foundation to use the funds for any purpose for which the Foundation was created. They may also be "restricted" or "earmarked" for specific purposes of interest to the donor.

In any event, all contributions to the CES Foundation are deductible for income tax purposes.

Dr. Pomainville Honored by CES Foundation

The State Medical Society's historian, Dr. Leland C. Pomainville of Wisconsin Rapids was honored by the Charitable, Educational and Scientific Foundation for his outstanding contributions "in encouraging interest in the preservation of medical history," in a ceremony at Society headquarters Oct. 3.

Doctor Pomainville, who received an engraved plaque, was cited for his efforts in the creation of a library of Wisconsin medical history, formation of the Museum of Medical Progress at Prairie du Chien, and establishment of a scholarship award for medical students interested in medical history.

In addition to being the Society's historian, he is a member of the Board of Trustees of the CES Foundation.

This special CES Foundation award was created to honor individuals or groups who have made significant contributions to the promotion of medical history, public health education programing, or the advancement of the Foundation itself. Doctor Pomainville is the first recipient.

Recipients of the award are determined by the Executive Committee of the Foundation.

DR. LELAND C. POMAINVILE (center) of Wisconsin Rapids accepts engraved plaque from Dr. William D. Stovall (right) of Madison, president of the CES Foundation, and Dr. William D. James (left) of Oconomowoc, president of the State Medical Society, in a ceremony at SMS headquarters Oct. 3, in recognition of his interest in medical history.

County Societies Have Major Role in SMS/CES Foundation

The Charitable, Educational and Scientific Foundation of the State Medical Society was created in 1955 by action of the House of Delegates. It came into being as a natural outgrowth of a trust created by the Society four years earlier to administer a student loan fund.

The CES Foundation is a nonstock corporation under Wisconsin statutes. It is directed by a Board of Trustees composed of an elected member from each component county medical society, the Councilors and Officers of the State Medical Society and up to 15 nonmedical trustees.

Terms of the county society representatives are for three years with about one-third being elected each year. This helps to insure stability in the board.

Although the membership of the Board of Trustees numbers 90, the officers and executive committee constitute a small enough number to work efficiently in governing the routine affairs of the Foundation.

The officers of the State Medical Society, the officers of the Foundation, and certain appointed trustees constitute the Executive Committee of the Board. A meeting of the entire Board is held at least annually. Officers are elected at that time. The Executive and other committees meet periodically throughout the year.

With a continuing liaison at the county medical society level throughout Wisconsin, and with the Foundation integrated with the governing body of the State Medical Society itself, the traditions and continuity of organized medicine in Wisconsin can be assured.

Furthermore, such an arrangement provides some assurance that projects and activities undertaken by the Foundation will reflect the personal, human, and realistic approach to many problems of medicine and public health.

EXHIBIT FEATURES LISTENING DEVICE

The stethoscope, Rene Laennec's invention which revolutionized physical examinations, is an object of a special exhibit donated to the CES Foundation by the Wisconsin Society of Internal Medicine in 1966.

The exhibit houses a group of instruments dating back to nearly 1816 when the first stethoscope was designed.

Twenty physicians from Wisconsin and seven other states contributed their old and valued stethoscopes upon learning that the Foundation was interested in creating such a collection.

Charitable, Educational and Scientific Foundation

of the State Medical Society of Wisconsin

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the wisconsin medical journal

VOLUME 67/NUMBER 12 DECEMBER 1968

Results of Radiation Therapy in Cancer of the Larynx

Based Upon Clinical Staging by the International TNM System

AN ANALYSIS OF 105 CASES

By JACOB H. MARTENS, M.D.
MAXINE E. BENNETT, M.D.
HALVOR VERMUND, M.D.
Madison, Wisconsin

■ THE INCIDENCE OF CANCER of the larynx is increasing (Fig 1) and the importance of optimal therapy needs to be emphasized.

Many patients with cancer of the larynx are still referred too late for therapy. All patients with progressive hoarseness, throat pain or dysphagia of more than two weeks duration must be referred for indirect laryngoscopy and direct laryngoscopy with biopsy if there is the slightest suspicion of carcinoma.

Modern radiotherapy has made it possible to cure a high percentage of the less-advanced tumors without sacrificing the voice. The 5-year cure rate of early vocal cord cancers is equal to that obtained with surgery.

In patients with more advanced tumors radiotherapy is followed by a higher incidence of recurrence, but in patients with persistent cancer laryngectomy offers a second chance for control of the tumor. Preoperative radiotherapy lowers the local recurrence rate and improves results in the advanced tumors.

From the Sections of Radiotherapy and Otolaryngology, University of Wisconsin Medical School. Doctor Martens is a Resident in Radiology; Doctor Bennett, Professor of Surgery; and Doctor Vermund, Professor of Radiology.

Supported by Grant No. CA 06295-07 RAD from the National Institutes of Health.

Reprint requests to: Halvor Vermund, M.D., Orange County Medical Center, 101 South Manchester Avenue, Orange, Calif. 92668.

Materials and Methods

All cases of carcinoma of the larynx treated with radiation therapy at the University of Wisconsin Hospitals during the 8-year period between 1954 and 1962 were

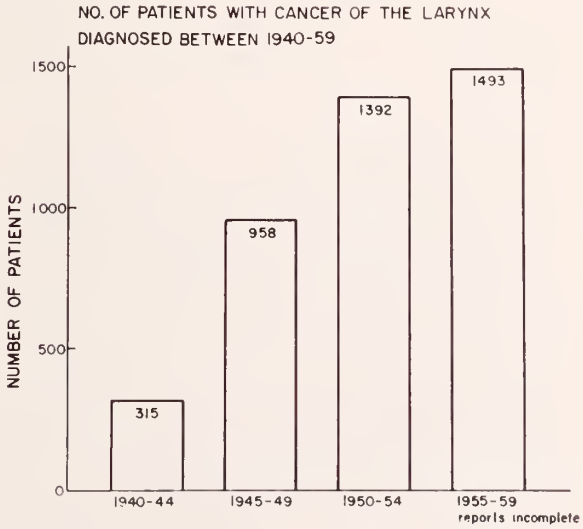

Fig. 1—Incidence of cancer of the larynx as published by the Clinical Section of the National Cancer Institute based on data collected from three central cancer registries (California, Connecticut, and Massachusetts) and 10 individual hospitals (Albert Einstein, Philadelphia; Charity Hospital, New Orleans; Indiana University Medical Center; New York Medical College; Roswell Park Memorial Institute; State University of Iowa Hospital; University of California Hospital, San Francisco; University of Chicago Clinics; University of Michigan Hospitals, and University of Virginia Hospitals).

reviewed. There were 105 patients in this series, 68 having been treated with irradiation alone, 18 with initial surgical intervention followed by irradiation for recurrence, 11 with laryngectomy or laryngofissure followed by postoperative radiotherapy, and 8 with irradiation followed by laryngectomy.

Six patients received chemotherapy (5-fluorouracil) in combination with radiotherapy. Five of them had far advanced cancer and treatment was purely palliative. The sixth patient was treated for a glottic Stage II carcinoma and is living well with a normal voice five years after therapy.

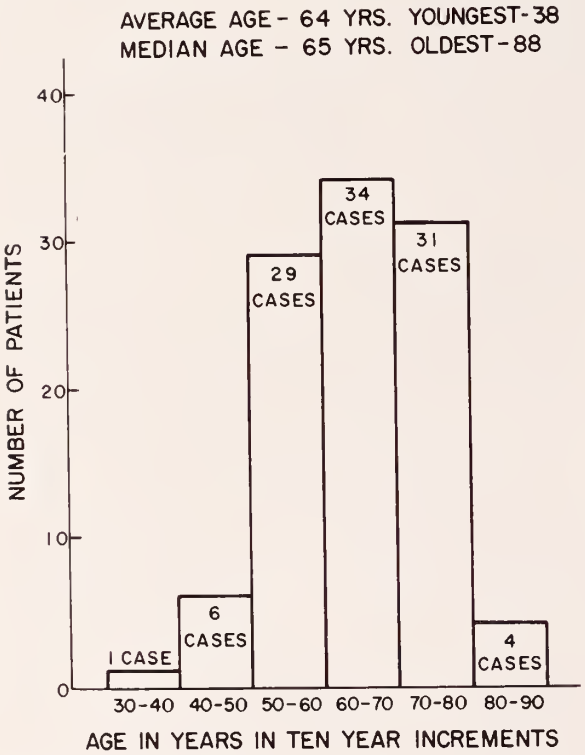

Fig. 2—Age distribution of 105 patients with cancer of the larynx treated at the University of Wisconsin between 1954 and 1962.

The surgery was performed by the attending or resident staff of the Department of Otolaryngology or by practicing otolaryngologists. No patient was lost to follow-up.

Age varied from 38 to 88 years (median 65, average 64) (Fig 2). There were 35 patients who were more than 70 years of age.

Sex. Only 2 females were encountered, illustrating the marked preponderance of cancer of the larynx among males.

Staging was carried out according to the system developed by the International Union Against Cancer[2] based upon the extent of the disease. Where there was some question as to the assignment to a higher or lower stage, the patient was placed in the lower stage. Patients with tumors largely occupying structures outside the larynx were excluded even though they might involve the larynx secondarily.

The TNM system of staging was employed as follows:

Primary Tumor

T_1: Tumor confined to the one anatomic site of origin (e.g., vocal cord, false cord, ventricle, epiglottis, aryepiglottic fold, arytenoid or subglottic).

T_2: Tumor extending outside the site of origin but still confined to one of the three regions: (1) supraglottic [false cords, ventricles, epiglottis, aryepiglottic folds, arytenoids]; (2) glottic [vocal cords, anterior commissure]; fixation of one cord in patients with tumors of the vocal cord places the patient in this category; (3) subglottic.

T_3: Tumor extending beyond the region of origin but still confined to the larynx (e.g., glottic tumor extending to the supraglottic or subglottic area, or supraglottic or subglottic tumor extending onto the vocal cords).

T_4: Tumor extending beyond the larynx (e.g., into the hypopharynx).

Lymph Nodes

N_0: No clinically palpable metastatic nodes.

N_1: Homolateral movable clinically metastatic nodes.

N_2: Homolateral fixed or bilateral movable nodes.

N_3: Bilateral fixed nodes.

Distant Metastases

M: Distant metastases present.

On the basis of the TNM symbols, the patients were classified into four stages as follows:

Stage I: T_1N_0.

Stage II: T_1N_1, T_2N_0.

Stage III: T_1N_2, T_2N_1, T_2N_2, T_3N_0, T_4N_0, T_3N_1, T_4N_1, T_3N_2, T_4N_2.

Stage IV: $T_{1-4}N_3$, $T_{1-4}N_{0-3}M$.

The distribution of the patients by clinical stage is given in Figure 3. The majority belonged to the advanced Stages III and IV as evidenced by 84 patients (80%) being assigned to these categories.

Multiple Primary Tumors

In 13 patients second primary tumors were diagnosed either before, during, or after therapy for carcinoma of the larynx. The distribution of these tumors is given in Table 1. The time interval between the diagnosis of the first and second primary tumor varied from 0 to 6 years.

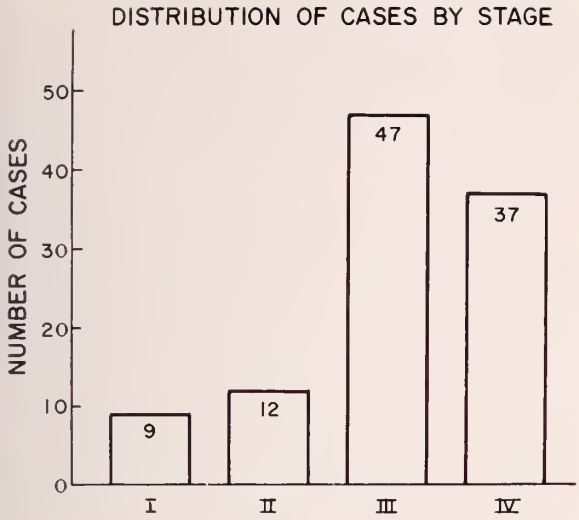

Figure 3

Symptoms and Signs

Hoarseness was present to varying degree in all the patients with glottic carcinoma. The average duration of this symptom was 7.7 months. In patients with supraglottic carcinomas, the initial major complaint was as likely to be throat pain and dysphagia (20 cases) as hoarseness (21 cases). A mass in the neck was the major initial sign in 5 patients.

Secondary Symptoms

Loss of weight (21 patients), dyspnea (15), dysphagia (15), pain in the throat or ear (13), hemoptysis (10), mass in neck (5), cough (4) were observed as the tumor progressed.

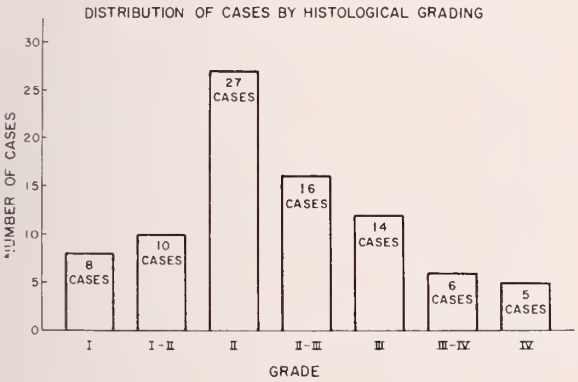

Figure 4

Histology

All tumors were histologically verified by biopsy as squamous cell carcinoma. Histological grading was performed in 86 cases (Fig 4). The glottic tumors were usually more differentiated than the supraglottic ones which showed a greater propensity for lymphatic spread. The relationship between histological grading and clinical stage is illustrated in Figure 5. The greater majority of the tumors fell into the intermediate or poorly differentiated categories and were clinically staged III to IV. No poorly differentiated tumors were encountered in Stages I and II.

TABLE 1—*Second primary tumors in patients with cancer of the larynx*

Esophagus	3
Skin	3
Lung	2
Nasal Fossa	1
Tonsil	1
Sigmoid Colon	1
Bladder	1
Testis	1
TOTAL	13

TABLE 2—*Associated diseases in patients with cancer of the larynx*

Active pulmonary tuberculosis	3
Inactive pulmonary tuberculosis	3
Cardiovascular disease	22
Cerebrovascular arteriosclerosis	8
Liver cirrhosis	4
Diabetes mellitus	2
Bronchial asthma	2
Gout	2
Peptic ulcer	1
Dermatitis herpetiformis	1
Von Willebrand's disease	1
Epilepsy	1
Psychosis	1
Rheumatoid arthritis	1
TOTAL	52

Effects of Smoking and Drinking

The smoking habits of 78 patients were recorded. Of them, 71 smoked cigarettes, the overwhelming majority heavily (one pack or more a day). Only 2 patients had never smoked.

The drinking habits were recorded in 63 patients. Of these 40 admitted to regular heavy intake of alcoholic beverages, 13 to moderate consumption, and 10 denied alcohol intake. There were 7 bartenders or tavern keepers in this series.

Associated Diseases

Approximately 50% of the patients in this series of elderly individuals suffered from clinically evident coexisting illness (Table 2). Eleven patients died from intercurrent disease and 4 from secondary primary cancers before the end of five years after the treatment. These findings suggest a certain de-

Histology					
Well differentiated Grade I - II	3	3	8	4	18
Intermediate Grade II - III	4	7	29	17	57
Poorly differentiated Grade III - IV	0	0	5	6	11
Total	7	10	42	27	86
	I	II	III	IV	Total
	Stage				

Fig. 5—Histologic grading versus clinical staging.

gree of pre-selection with patients considered poor surgical risks being preferentially referred for radiation therapy.

Treatment Methods

Two basically different radiotherapeutic methods were employed:

(1) A method employing a rapidly delivered dose of roentgen radiation with high daily increments resulting in marked mucositis was used until 1957 under the direction of the late Professor E. Pohle.

Two different qualities of radiation were employed:

(a) 200 kilovolt, 1 mm copper filtration, half-value-layer 1.1 mm copper, 50 cm focal-skin-distance, 200 R/air per day to each of two lateral ports for an average of 12 treatments over a total period of two weeks;

(b) 1000 kilovolt, half-value-layer 9 mm copper, 70 cm focal-skin-distance, single lateral or opposing lateral ports, daily dose of 270–300 R/air for a total of 12 to 18 treatments over two to three weeks.

(2) After 1957, 1000 kilovolt x-rays were employed exclusively delivering an average tumor dose of approximately 6000 r (5760 rads) over approximately six weeks to small fields 5 x 6 cm square or a slightly lower dose with larger ports in advanced lesions.

Results

Early Lesions (Stage I)

Patients with early lesions responded well. The voice of the survivors was good. Two attorneys were able to continue practicing law after radiotherapy. Three patients died from intercurrent disease without having shown evidence of recurrence of the vocal cord carcinoma. Only 2 patients died of cancer of the larynx, one having been treated palliatively with 5000 rads in five weeks for recurrence in a pharyngocutaneous fistula 14 months after laryngectomy and the other with radiotherapy alone 4100 R/a over 17 days. There was one patient with a supraglottic carcinoma who survived five years without recurrence following radiotherapy alone.

Two of the 9 patients had been treated with surgery initially. One had a laryngofissure and radiotherapy following the operation, and was living without cancer 11 years later; the other had laryngectomy and received radiotherapy for recurrence but died 14 months after the operation.

Seven of the 9 patients received radiotherapy alone. Among the 4 who received what is now considered to be an adequate dose (more than 5000 rads in four to five weeks, or 6000 rads in six weeks), no recurrence occurred.

Early Lesions T_2N_0 (Stage II)

Seven of the 12 patients survived three years and 5 survived five years without recurrence. Four additional patients died from intercurrent disease without cancer before the five-year period ended. One of these died at the age of 83 from heart failure, another at the age of 74 from a stroke, a third at the age of 73 from a coronary occlusion, and a fourth patient from carotid artery rupture following radical neck dissection and radiotherapy. Three patients died of recurrence after 11, 28 and 45 months respectively. Among the 7 patients with glottic tumors, 3 of these lived five years without recurrence, 3 died of intercurrent disease and 1 of cancer. All 3 long-term survivors (60, 72, and 133 months respectively) received radiotherapy alone.

There was fixation of the cord in 2 patients. Both were treated with radiation therapy alone and were well 60 and 133 months later. The cord was sluggish in 2 patients. One is well 74 months later; the other died of intercurrent disease with no evidence of cancer present after five months.

There were 5 patients with supraglottic tumors. Two of these survived five years without recurrence. One died of a coronary occlusion 38 months after radiotherapy and had no recurrence. Two patients died of cancer. One had had total laryngectomy, developed cervical node metastases, and was treated with 6000 r to the tumor over 59 days with complete resolution of the enlarged cervical nodes; but pulmonary metastases developed nine months later.

Stage	No.	Alive 5 years	Died of intercurrent disease before the end of 5 years	Died of 2nd primary tumor	Died of laryngeal cancer	Net 5-year survival
T_1N_0	9	4	2	1	2	
	21	9=43%	6=29%		24%	9/14=64%
T_2N_0	12	5	4		3	
T_3N_0	31	7	5	1	20	
	46	10=22%	6=13%		65%	10/40=25%
T_4N_0	15	3	1	1	10	
$T_{2-4}N_{1-3}$	34	2	5	2	30	
	38	2=5%	5=13%		90%	2/38=5%
M	4	0	0		4	
	105	21=20%	17=16%	5	69=66%	21/92=23%

Fig. 6—Results in different stages of cancer of the larynx.

The other received 5000 r to the tumor over 26 days and died from a local recurrence 28 months later.

Both of the two long-term survivors had received radiotherapy only. One of them died 97 months after treatment from a squamous cell carcinoma of the posterior pharyngeal wall. The other developed recurrent cancer of the larynx 78 months after treatment with 6200 r to the tumor over 32 days. The fifth patient with a supraglottic tumor died of a myocardial infarction about three years after therapy.

Advanced Lesions T_3N_0

The results in the more advanced lesions were less satisfactory. Only 9 of 31 patients survived three years, and 7 survived five years. Two died of late recurrences. Three patients died of intercurrent disease and one of a carcinoma of the esophagus, probably a second primary.

Three of the 7 patients who survived five years had had radiotherapy alone with dose levels in excess of 6000 r to the tumor in 27 to 36 days. Two of them were well at 66 and 78 months; the third died of a ruptured abdominal aneurysm with no evidence of cancer 71 months after therapy. The fourth patient was treated with laryngofissure followed by total laryngectomy three years later when the tumor recurred locally, had a radical neck dissection a year later, and was finally treated with radiotherapy because of a recurrent mass in the neck. He finally died of his cancer of the larynx 67 months after the initial operation. The fifth patient is well 64 months after total laryngectomy and radical neck dissection followed by 6000 r to the neck over 41 days.

The sixth patient was treated initially with radiotherapy but developed recurrence two years later. A total laryngectomy was done but a recurrence developed in the stoma. The patient was treated with chemosurgery, chemotherapy, and radiotherapy and is free of tumor more than five years after the initial therapy.

The seventh and final patient received 3336 R/a over 15 days, developed a recurrence, underwent partial laryngectomy and survived 73 months without recurrence. He died from emphysema and heart failure.

There were 20 patients who died of cancer of the larynx within three years in spite of all therapeutic efforts. Ten of these had been treated with radiotherapy alone, the remaining 10 with surgery and irradiation.

There were 8 supraglottic tumors in this group with 2 five-year survivors, 22 glottic tumors with 4 five-year survivors, and one subglottic tumor which was successfully treated with radiotherapy alone.

Advanced Lesions T_4N_0

Four of 15 patients with T_4N_0 lesions survived three years, and 3 survived five years without recurrence. Even though the yield was low, the prognosis was not entirely hopeless as long as there were no clinically manifest lymph node metastases.

One of the survivors was treated with 6400 r to the tumor over 33 days (1000 KV x-rays) and lived 83 months without recurrence of his tumor. He died of cardiac failure. The 2 others were treated with surgery and irradiation, and both are alive without recurrence 71 and 124 months respectively. Two patients died of intercurrent disease and were free of cancer of the larynx at the time of death. The remaining 10 patients died of cancer of the larynx; 3 of these had surgery and irradiation, the other 7 were considered inoperable and received radiotherapy alone. In 5 patients the dosage was low and considered palliative only.

Cervical Node Metastases N_{1-3} Lesions

Once cervical node metastases had developed, the survival rate became very poor and only 2 patients were living free of cancer beyond the five-year period. The first patient had a laryngectomy for a supraglottic lesion, one year later developed a 9 x 11 cm fixed cervical mass which was biopsied and found to be recurrent squamous cell carcinoma and was treated with a 3-plane radium implant with 7000 r in 7 days (74 mg for 168 hours). This patient remains free of disease 93 months after the initial laryngectomy and 79 months after the radium implant. The other patient underwent a total laryngectomy and radical neck dissection—six years later a 3 x 3 cm recurrent mass developed 2 cm above the stoma. The tumor was resected, but because of extensive invasion a segmental resection of the upper esophagus had to be made. The operation was followed by 5000 r to the tumor bed over 37 days. This patient is well 88 months after the total laryngectomy and 25 months after the irradiation.

The remaining 32 patients died from cancer of the larynx—only 9 had been treated with surgery and radiation, 23 were inoperable and received palliative radiotherapy only.

These data have been summarized in Figure 6 and illustrate the prognostic significance of clinical staging: Whereas 24% of patients with early lesions ($T_1T_2N_0$) died from cancer, 65% of those with the more advanced lesions ($T_3T_4N_0$), and 90% of those with metastases ($N_{1-3}M$) succumbed. The highest incidence of death from intercurrent disease occurred among the patients with early lesions (29%). Similarly, the net five-year survival decreased from 64% in Stages I and II to 25% in T_3T_4, and to 5% in the more advanced stages.

Survival in Relation to Treatment Modality

In Table 3 are summarized the three-year survival of patients with cancer in different stages related to treatment modality.

Group A: Radiotherapy alone in the early $T_1T_2N_0$ lesions resulted in 10 of 17 living and free of clinical evidence of cancer for three years. Five patients died from intercurrent disease without having shown evidence of recurrent laryngeal tumor. The absolute three-year survival is, therefore, 59% and the relative or determinate three-year survival 83% (10 of 12).

The results of radiotherapy alone in the more advanced cases were unsatisfactory with only 4 of 25 patients with T_3N_0 and T_4N_0 lesions and none of 26 patients with cervical node metastases surviving three years. Among the latter were 4 patients with distant metastases (M) with an average survival of seven months (range 3 to 11 months).

Group B: Patients with recurrence after laryngofissure or laryngectomy were referred for radiotherapy but results of therapy were poor with a three-year salvage rate of only 26% (5 of 19 patients). Only 3 of these 5 surviving patients remained alive free of disease for five years. One of the surviving patients had a T_3N_0 lesion and developed lymph node metastases after the laryngectomy, underwent a radical neck dissection, and received prophylactic postoperative radiotherapy. The other 2 had lymph node metastases, one treated with neck dissection and radiotherapy, and the other with radiotherapy alone.

Group C: Postoperative radiotherapy was given to 11 patients after laryngectomy and to 1 after laryngofissure because of incomplete removal of the cancer. There were 6 three-year survivors but only 3 were alive and free of cancer at five years. Two died of intercurrent disease and 1 of a second primary bronchogenic carcinoma.

Group D: Three of 6 patients with recurrent tumor after irradiation were treated with laryngectomy and survived three years. Two of these lived five years and both had T_3N_0 lesions.

Survival Related to Dosage of Radiation

Increased survival was apparent at dosages exceeding 6000 r (5760 rads) calculated

TABLE 3—*Survival and treatment modality in 105 cases of cancer of the larynx Absolute 3-year survival/total number treated*

GROUP		A	B	C	D
Stage	Total No.	Radiation Alone	Laryngofissure or Laryngectomy + Radiation for Recurrence	Postoperative Irradiation	Irradiation + Laryngectomy for Recurrence
T_1N_0	5/9	4/7*	0/1	1/1	
T_2N_0	7/12	6/10**	1/2***		
T_3N_0	9/31	3/16	2/7	2/5	2/3
T_4N_0	4/15	1/9	0/1	3/4	0/1
$T_{2-4}N_{1-3}$ M	3/38	2/26	2/8	0/2	1/2
	28/105 (27%)	14/68 (20%)	5/19 (26%)	6/12 (45%)	3/6 (50%)

*2 died of intercurrent disease without clinical evidence of cancer.
**3 died of intercurrent disease without clinical evidence of cancer.
***1 died of intercurrent disease without clinical evidence of cancer.

central axis minimal tumor dose over approximately six weeks (Table 4). Among 41 patients treated with the higher dose there were 17 three-year survivors (42%). Only 11 of 64 (17%) treated with the lower dose survived this length of time. The improved survival was reflected most in the earlier cases with 7 of 9 (78%) treated with higher doses, versus 5 of 12 patients (42%) with the lower doses, surviving three years. The dosage dependence becomes even greater when taking into consideration that 3 of 11 survivors after the lower dose were salvaged by surgical procedures. The local radiation control rate after the higher doses was, therefore, 17 of 41, or 42%, as compared to only 8 of 60, or 13%, after the lower dose (deleting the 4 cases with distant metastases).

The three- and five-year survivals have been summarized and divided into glottic and supraglottic tumors according to stage (Table 5).

Patients with early (Stage I) supraglottic tumors did fairly well (5 of 6 surviving three years and 3 of 6 surviving five years). Patients with early glottic tumors (Stage I and II) seemed to fare less well (7 of 15 surviving three years and 6 of 15 surviving five years), but 5 of the patients in the latter group died of intercurrent disease, free of tumor. The determinate three-year survival is, therefore, 7 of 10 and the five-year survival 6 of 9. The 3 patients who died of recurrence had what is now considered a less than optimal dose of roentgen radiation (less than 5000 rads).

There were 6 three-year and 4 five-year survivors among the 30 patients with Stage III glottic tumors, and 7 three-year and 5 five-year survivors among the 24 patients with supraglottic tumors of the same stage (Table 5). No patients with advanced (Stage IV) glottic tumors ($T_{1-4}N_3$ lesions) survived, whereas 2 patients with supraglottic tumors survived five years.

The sole patient with a subglottic lesion (T_3N_0) was treated with radiotherapy alone, and is living and well more than five years later. He received a tumor dose of 6150 r over 36 days.

Complications

There were no recorded significant complications from treatment of the early lesions (T_1, T_2, N_0) in 21 patients although the mucositis and edema produced temporarily by the radiotherapy increased hoarseness and dysphagia.

In the advanced cases, however, the complication rate increased significantly. One patient with a T_4N_3 lesion died during emergency tracheostomy from edema after having received 4080 r to the tumor over a period of 34 days. This was the only mortality which could be ascribed directly to radio-

TABLE 4—*Absolute 3-year survivals related to dosage of radiation*

Stage	6000 r/t or more No. Surviving / No. Treated	Less than 6000 r/t No. Surviving / No. Treated	Total
T_1N_0	2/3	3/6	5/9
T_2N_0	5/6	2/6	7/12
T_3N_0	5/15	4/16**	9/31**
T_4N_0	3/8	1/7	4/15
$T_{2-4}N_{1-3}$	2/9	1/25*	3/34*
M_4		0/4	0/4
TOTAL	17/41=42%	11/64=17%	28/105=27%
*Surgical salvage of radiation failures	0	3/6	3/6

Each (*) means one patient.

therapy. Eleven patients developed fistulas (tracheoesophageal, pharyngocutaneous or esophagocutaneous) requiring nasogastric tube feedings. These occurred after combined surgical and radiation treatments. In most cases there was spontaneous closure; in others, skin grafting was necessary. The combination of tumor and fistula signified a rapid terminal course.

Chondritis resulting from tumor invasion and/or irradiation was encountered in 5 patients. In these, total laryngectomy was performed whenever feasible. In some patients with far advanced cancer, tracheostomy only was carried out. Stricture of the stoma without recurrence was found in 2 patients. Tracheal or esophageal obstruction due to tumor with aspiration bronchopneumonia was a frequent terminal event. Extensive wound infection with slough, and hemorrhage from neck vessels was encountered in 3 patients. Severe neuralgic pains requiring neurosurgical procedures developed in 2 patients, probably as a result of uncontrolled tumor. One patient died of delirium tremens.

Discussion

Treatment of cancer of the larynx is based upon close cooperation between experienced otolaryngologists and radiotherapists. Agreement on treatment policy must be established and therapy should be decided upon jointly after the clinical stage of the tumor has been determined. The treatment must be planned so as to give the patients the best possible chance for a cure and to produce the maximal preservation of laryngeal function. Radiotherapy and surgery are supportive and the initial therapy must be selected so that the maximal benefit to the patient is achieved.

In comparing results from different institutions it is essential that the stages of the tumors be known. The international system of staging[2] has been widely adopted and has been helpful in formulating a consensus as to the optimal form of therapy for the individual patient. The staging system demands great precision in diagnosis and has been of value in defining the indications for radiotherapy and surgery. The determination of the exact stage of a tumor is no easy task even on direct laryngoscopy and must be supplemented by soft tissue radiography, tomography and laryngography. Nevertheless, the pathologist often reports that some tumors are more extensive than evidenced by the clinical staging.

When comparing results it is important to obtain both the absolute (crude) and the relative (net, determinate) survival because there is a considerable death rate from intercurrent disease and, in some institutions, patients are lost to follow-up. Patients whose fate is undetermined are frequently excluded and the statistics reported are therefore only relative or determinate.

The following recommendations on therapy may be offered:

I. Glottic lesions

(a) *Stage I*—T_1N_0 glottic lesions have a good prognosis. Laryngofissure with cordectomy or radiotherapy results in comparable five-year cure rates. Determinate five-year survivals around 90% can be expected. The incidence of recurrence after radiotherapy has been reported as high as 11%[3] but is usually lower.[4–8]

Radiotherapy is now the recommended therapy because a high percentage of the patients retain a normal voice. Nielsen[4] reported excellent voice in 100 of 108 patients who had survived for five years or more after x-ray therapy.

(b) *Stage II*—T_2N_0 lesions can also be cured with radiotherapy with preservation of a good voice, but the five-year survival rates are not quite as good as in Stage I. Most institutions report about 70% five-year survival. This figure includes some patients with recurrence, salvaged by total laryngectomy, but the number of patients requiring subsequent surgery usually does not exceed 10%.[4, 6, 9–11]

Fixation of a vocal cord frequently means a less favorable prognosis after radiotherapy. Nevertheless, about 40% of the patients in this group will survive five years after initial radiotherapy as compared with 60% after initial surgery.[3, 12–15]

(c) *Stage II*—T_3N_0 lesions show a greater incidence of local recurrence or persistence after radiotherapy and total laryngectomy becomes necessary in a larger percentage of patients. Tumors frequently regress and ulcerations heal so that it may be difficult to obtain positive biopsies after irradiation. Nevertheless, neoplastic cells may remain in the deeper structures, particularly in deeply infiltrating tumors. Initial radiotherapy with surgery for radiation failures has produced a five-year survival of approximately 50% as compared to 60% with initial

TABLE 5—*Absolute survival according to stage*

Stage	I		II		III		IV		Total	
Years Survival	3	5	3	5	3	5	3	5	3	5
Glottic	4/8	3/8	3/7	3/7	6/30	4/30	0/5	0/5	13/50	10/50
Supraglottic	1/1	1/1	4/5	2/5	7/24	5/24	2/21	2/21	14/51	10/51
Subglottic					1/1	1/1			1/1	1/1
Indeterminate							0/3	0/3	0/3	0/3
Total	5/9	4/9	7/12	5/12	14/55	10/55	2/29	2/29	28/105	21/105
%	56	44	58	42	25	18	7	7	27	20

surgery.[3,5,12,13,16] If primary radiotherapy is successful the patients usually retain their normal voice. Studies in progress suggest that the best survival in this group of patients can be anticipated with planned preoperative radiotherapy followed by radical laryngectomy and neck dissection.[17,18]

(d) T_4N_0 lesions which have extended outside the larynx have a very poor prognosis with radiotherapy alone with less than 15% of the patients surviving five years.[3,5,13,19] The results from surgery are not satisfactory either and preoperative radiotherapy followed by total laryngectomy plus partial pharyngectomy and radical neck dissection appears to yield the best results in patients who are in sufficiently good condition to tolerate these procedures.

II. Supraglottic lesions

Early lesions (T_1N_0, T_2N_0) are rare but are curable with radiotherapy. The five-year survival rates have been running about 60% to 70% with radiotherapy as the primary form of therapy and have been comparable to those following primary laryngectomy.[3,5,6,11,20–23]

In the advanced supraglottic tumors (T_3N_0, T_4N_0) preoperative radiotherapy followed by total laryngectomy and radical neck dissection is the preferred method in most institutions, but postoperative radiotherapy may also be of value.[24,25]

III. Subglottic tumors

Subglottic tumors have a tendency to infiltrate down the trachea and produce obstruction and stomal recurrences. Primary radiotherapy followed by total laryngectomy in patients who show persistence or recurrence has produced five-year survival rates around 40% as compared to surgery alone which has yielded about 30%.[1,3–5,11,21,26–29] The best treatment may be planned preoperative radiotherapy and total wide laryngectomy with radical neck dissection.

Patients who have to undergo pre-irradiation tracheostomy have had a low five-year survival rate (averaging about 20%)[1,11,12,21] and a high incidence of stomal recurrence (about 40% as compared to an overall incidence after total laryngectomy of 10%.[30–33]

Small daily doses of radiation together with antibiotics and corticosteroids may often relieve the obstruction and the tracheostomy may be avoided. Four to six weeks after the course of preoperative radiotherapy has been completed the definitive surgery can be performed.

IV. Lymph node metastases ($N_{1,2,3}$)

Radiotherapy alone produces unsatisfactory results in patients with unilateral mobile lymph node metastases (N_1 lesions) with five-year survivals averaging about 15% as compared to 35% after radical neck dissection.[3,5,6,9,12,19,20,34–39] In patients with large fixed or bilateral node metastases the prognosis is almost hopeless and palliation is all that can be anticipated. A few patients can be made operable by radiotherapy and a modest five-year survival rate can be expected.[5,6,19,36,38]

Postoperative radiotherapy may be of value. French authors[24,25] reported a 40% five-year survival in a series of 140 patients with supraglottic tumors and cervical node metastases.

In their series there were 10 of 26 patients (38%) surviving five years after total laryngectomy and postoperative radiotherapy as compared to 48 of 114 (42%) after total laryngectomy, radical neck dissection, and postoperative radiotherapy. Radiotherapy may be as important as elective radical neck dissection in supraglottic tumors without palpable neck nodes.[24,25] Preoperative radiotherapy followed by radical surgery is favored in this country by many investigators.[17,18] The purpose is to eradicate the relatively radiosensitive, rapidly dividing cells in the periphery of the tumor to prevent

local recurrence in the wound and lymphatics or vascular spread.

There are disadvantages to preoperative radiotherapy, but they are hopefully outweighed by the advantages of improved cure rates. There is agreement among surgeons and radiotherapists that the dose of preoperative radiation has to be limited in order to avoid increased incidence of postoperative complications, such as fistula formation, flap necrosis, and delayed wound healing. Five thousand rads delivered over five weeks is considered optimal by some[17,18] and the surgery is performed three to six weeks later. Goldman and coworkers[18] reported that 13 of 18 patients with Stage III laryngeal carcinomas were alive two years after such combined therapy.

Others have decreased the radiation dose and shortened the treatment time.[40,41]

Some investigators have objected to preoperative radiotherapy on the grounds that apparently normal larynges free of tumor on pathologic examinations have been removed.[28] The tumor was apparently completely destroyed by the irradiation. Others believe, however, that it is safer to remove the larynx and the regional lymph nodes in advanced tumors than to postpone surgery until definite evidence of recurrent tumor has been demonstrated because the statistical evidence points toward a high probability of recurrence.

The importance of careful planning cannot be overemphasized, because radiotherapy for recurrence after surgery is rarely successful. Among 150 such cases from the literature there were only 15 patients surviving five years.[3,25,42-48]

Re-irradiation for recurrence after radiotherapy is hazardous and associated with a high incidence of complication.[6,14,44,47,49] Radical surgery for late recurrence after irradiation may be difficult particularly if large volumes of tissue have been treated. Nevertheless, an average five-year salvage rate of about 50% after laryngectomy for radiation failures has been achieved.[3,6,8,12,15,21,26,28,36,47,50-54]

Summary

An account of the clinical features and results of treatment of 105 patients with cancer of the larynx is given.

The need for eliminating delay in diagnosis is apparent because of the large proportion of far advanced cases presently being referred for therapy.

The importance of clinical staging is emphasized. Radiotherapy is the choice of primary treatment in early and selected cases of moderately advanced tumors. Retention of the voice is an important consideration. A combination of radiotherapy and radical surgery offers the best chance for long-time survival in the advanced tumors.

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HEPATOCARCINOMA ASSOCIATED WITH BILIARY CIRRHOSIS

M. P. DEORAS, MD, Milwaukee County General Hospital, Milwaukee, Wis; and W. DICUS: *Arch Path* 86–338–341 (Sept) 1968

An analysis of cases of childhood liver cancer reveals a significant proportion of associated congenital anomalies or neonatal disease of the liver. These preexisting pathological conditions, viz., congenital biliary atresia, cirrhosis of liver, neonatal hepatitis, vonGierke's disease and de Toni-Fanconi syndrome, are important etiological factors in hepatic carcinogenesis.

A case which beautifully illustrates this phenomenon was seen at Milwaukee County General Hospital. A full-term normal Negro female child was found to have extrahepatic biliary atresia at the age of 3 months, as seen by exploratory laparotomy. A surgical reconstruction of the biliary system was attempted but without success. Liver biopsy showed marked bile stasis and early biliary cirrhosis. The child remained jaundiced and showed growth retardation. There were radiological signs of marked generalized osteoporosis and rickets. Clinically there were multiple fractures of long bones. She was maintained on calcium and vitamin D therapy.

At age 6 she had signs of cirrhosis with portal hypertension, as seen by repeated bouts of hematemesis from bleeding esophageal varices, which ultimately proved fatal. At autopsy a dark green and granular liver of biliary cirrhosis was identified. There was no evidence of functioning extrahepatic biliary system. In addition, multiple areas of yellow-white, diffuse, nodular structures were seen in the liver, which histologically proved to be hepatocarcinoma. There were metastases to the lungs. It is suggested here that congenital biliary atresia in due course led to the development of biliary cirrhosis on which hepatocarcinoma was superimposed at a much later date.

FLURANDRENOLONE TAPE

A New Therapeutic Measure in Dermatology

By FAUSTINO GOMEZ, M.D. and WILLIAM F. SCHORR, M.D., Marshfield, Wisconsin

■ THE USE OF TOPICAL corticosteroids covered by polyethylene film dressings is a rather well-established method in treating a variety of dermatological disorders. Recently polyethylene tape impregnated with flurandrenolone has been developed as a topical dressing.

In 1966, Weiner[1] treated 10 patients with psoriasis with the tape and concluded that it was at least as good as other occlusive therapy. He also cited the patients' preference for the tape over polyethylene wrap. Also in 1966, Goldman et al[2] found the tape useful in a series of 285 patients for localized lesions, wherever topical steroids were effective. These same authors[3] reported flurandrenolone tape to be as effective as fluocinolone acetonide under occlusive dressing, in partially inhibiting the delayed papular reaction to laser.

The subject of this report is the usage of an occlusive plastic tape, impregnated with a steroid on its adhesive side, in various dermatoses.

Material and Methods

Flurandrenolone tape made of polyethylene is a transparent, somewhat elastic, impermeable tape which has flurandrenolone incorporated into its adhesive substance in a concentration of 4 mcg/cm^2.[4] This layer has a paper backing which allows cutting of the tape into various shapes and sizes. The tape was applied directly to the involved skin and changed every 24 hours (Fig 1a, b, c). At the present time it is only available for supervised clinical studies.*

There were 42 patients involved in our investigation. The study was conducted using simultaneous varied controls: placebo tapes (26), flurandrenolone ointment (5), triamcinolone cream with occlusive dressing (2), flurandrenolone cream and ointment mixture (1), betamethasone cream in white petrolatum with occlusive dressing (1). The controls were applied to equal areas on symmetrical parts of the body in each patient.

Results

The predominating dermatosis treated was psoriasis (20). The remaining dermatoses are listed in Table 1. The palms and/or soles were involved in 17 patients (Table 2). The tape was used for a period of three weeks and the applications were changed every 24 hours. One patient was dropped from the study after six days due to his internment in a tuberculosis sanatorium. During the six days of therapy, however, his skin improved.

Thirty-six patients had excellent or good results. Five had equal improvement on the control side. One patient who showed only partial improvement responded better to the placebo tape. Worthy of mention are two patients who worked with cutting oils and

TABLE 1—*Treatment of dermatoses*

Dermatosis	No. of Patients	Results	
		Excellent or Good	Partial Improvement
Contact dermatitis	6	6	
Dermatitis	8	7	1
Dyshidrosis	2	1	1
Lichen planus	1	1	
Lichen simplex chronicus	1	1	
Nummular dermatitis	3	3	
Pityriasis rubra pilaris	1		1
Psoriasis	20	17	3
Totals	42	36	6

TABLE 2—*Treatment of dermatosis of palms and soles*

Dermatosis	No. of Patients	Results	
		Excellent or Good	Partial Improvement
Dermatitic and psoriatic lesions	17	13	4

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* Flurandrenolone (Cordran) tape is manufactured and was supplied by Eli Lilly and Company, Indianapolis, Ind.

Figs. 1 a, b, c—Technique of application of flurandrenolone tape. The tape is changed once every 24 hours by gently removing the old tape and applying a new layer.

Fig. 2a—Psoriatic plaque of soles of feet prior to treatment.

Fig. 2b—Therapeutic results three weeks later. The left foot was treated with flurandrenolone tape while the right was treated with placebo tape.

found that the tape provided an effective barrier and could be kept in place during work. Psoriatic plaques on women's arms and legs were less noticeable with the tape in place. This together with the rapid resolution of these lesions proved to be a definite advantage. Therapeutic results and ease of treatment of dermatologic lesions on the palms and soles appeared to be another distinct advantage.

Among the infrequent, but nevertheless present, disadvantages expressed by some individuals were (1) its tendency to cause excessive drying, (2) the appearing of folliculitis, and (3) difficulty in keeping the tape in place. Folliculitis caused one patient to discontinue therapy. Most patients found the flurandrenolone tape easier to use and less irritating than previous therapeutic methods.

Summary

Flurandrenolone tape for occlusive topical steroid therapy is described. A clinical investigation was made of 42 patients with various dermatoses. Controls which consisted principally of placebo tape or other topical steroid preparations were used. In one instance the placebo tape proved to be superior to the test tape. Results superior to previous treatments and to the controls were apparent in 86% of the patients studied.

The ease and convenience of application is an important factor. The greatest advantage was realized in female patients with unsightly psoriatic plaques on the exposed areas of the arms and legs and on resistant lesions of the palms and soles.

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USE OF DIETARY FLUORIDES

By JOSEPH M. DOHERTY, D.D.S., M.P.H., Madison, Wisconsin

■ THE ADDITION OF FLUORIDES to the public water supply in the recommended amounts of 1.0 to 1.5 parts per million in Wisconsin still remains the most safe, practical, efficient, and effective means of preventing dental decay. For those who do not have a fluoridated water supply a dietary supplement offers another means for the partial control of dental decay.

In prescribing the supplement the following considerations and precautions should be borne in mind:

1. The fluoride supplement should be taken continuously from infancy to 12 years of age to obtain the maximum benefits. By this age the crowns of all the teeth except the third molars should be completely formed. Irregular use of the supplement would be of only limited or no benefit. Therefore, only those families with a strong motivation and a clear realization of the need for regular and careful administration of the supplement should be considered.
2. Know the fluoride content of the water.[1] Supplementary fluoride should be prescribed only when the concentration of the fluorine ion in the drinking water is known and is less than 0.7 parts per million (0.7 mg/liter). This is especially important in Wisconsin because of the many communities now fluoridating and because of the presence of a natural fluoride belt in the eastern part of our state. The natural fluoride content in the belt runs up to 2.6 parts per million. Information regarding the fluoride status of a community may be obtained from the Dental Health Section of the Wisconsin Division of Health, P. O. Box 309, Madison 53701, or from the water superintendent of the community. Water sample bottles may be obtained and water samples submitted to the Wisconsin State Laboratory of Hygiene, 437 Henry Mall, Madison 53706, for fluoride analysis. Please request fluoride analysis on the forms enclosed in the water sample kit. This service is provided free of charge.
3. Because of the potential danger of accidental poisoning, no more than 264 mg of sodium fluoride (120 tablets of 2.2 mg) should be prescribed at one time and should bear the warning: Caution: Store out of reach of children.
4. Many dentists and physicians are prescribing dietary supplements for their patients; therefore, it is advisable to check with either the family physician or dentist as the case may be to be sure they are not already receiving supplements.

Doctor Doherty is Deputy Chief, Section of Dental Health, Wisconsin Division of Health.

TABLE 1—*Tablet dosage of supplemental fluoride when drinking water is substantially devoid of fluorine**

Age (Years)	Dosage	How Often	Method of Administration
0–2	One fluoride tablet (1 mg fluoride) to each quart of water	As needed	Preparing formulas and other foods
2–3	One fluoride tablet (1 mg fluoride)	Every other day	Fruit juice or drinking water; consume at one time
Over 3	One fluoride tablet (1 mg fluoride)	Each day	Fruit juice or drinking water; consume at one time

*Prescribing supplements of dietary fluorides, *J.A.D.A.* 56:590, 1958.

The Council on Dental Therapeutics of the American Dental Association has recommended a dosage schedule, using fluoride tablets, for children whose drinking water is essentially devoid of fluorine (Table 1).

In communities where the fluoride content is known to be below 0.7 ppm but more than 0.0 ppm the supplemental dosage should be cut in proportion to the amount of fluorine in the water.

Sample prescriptions which may be used in dispensing tablets and taking into consideration the variation of fluorine content are as follows: (Table 1) Where the fluoride content is 0.4 ppm to 0.7 ppm, reduce the tablet dosage by half so that the directions read as follows: One-half tablet daily in one quart of water for children under 2 years, one-half tablet every other day from 2 to 3 years and one-half tablet daily from age 3 to 12.

Although the above prescriptions are based on the tablet, it should be noted that there are several proprietary preparations of sodium fluoride on the market in either liquid or tablet form which allow a change of dosage according to the age of the child and natural fluoride content of the water.

The use of a dietary supplement is apparently a successful attempt in translating to individual use the experience gained from water fluoridation where the maximum number of persons receive the desired dental benefit without the danger of systemic effects to any individual in the community. The Council based the dosage schedule on the estimated daily intake of water when the water contained 1.0 ppm of fluoride (Table 2).

TABLE 2—*Estimated daily intake of water and fluoride ion when water contains 1.0 ppm of fluoride**

Age (Years)	Body Weight [Kg (Lb)]	Water Intake (Liters)	Fluoride Intake (Mg fluoride)
1–3	8–16 (18–36)	0.390–0.560	0.39–0.56
4–6	13–24 (29–53)	0.520–0.740	0.52–0.74
7–9	16–35 (36–77)	0.650–0.930	0.65–0.93
10–12	25–54 (55–119)	0.810–1.160	0.81–1.16

*McClure, F. J.: Ingestion of fluoride and dental caries, *Am J Dis Child* 66:368, 1943

Under these conditions the fluoride intake of children 1 to 3 years of age was estimated to be 0.39 to 0.56 mg; the fluoride intake from birth to 2 years of age, however, has been the subject of considerable debate. The Council thought that since all of the drinking water of infants might be provided in the home, it appeared possible to simulate the conditions existing in a community where the water supply is fluoridated. The Council felt, however, that the procedure suggested for infants would not logically apply to the older child who would be consuming a substantial amount of his drinking water away from home.

The effectiveness of systemic fluoride administration has been supported by studies of Feltman[1] and Arnold.[2] Both studies, however, lacked controls and Doctor Arnold noted that "evidence of the cariostatic effect of daily consumption of fluoride tablets in this study is necessarily presumptive, since the data cannot be compared directly with data obtained from a control group." Additional studies have been reported, however, that support the effectiveness of dietary fluorides, several of which have been done in European countries. None of the studies except Arnold and Feltman, however, have reported anywhere near the reduction in dental decay as has been reported for water fluoridation. Fluoridation gives a 60 to 65 percent reduction whereas the supplementary studies report a reduction of approximately 30 to 35 percent.

Prenatal Fluorides

There is considerable controversy in the literature about the administration of prenatal fluorides for the prevention of dental caries. Feltman and Kosel,[2] supported by Blayney and Hill[3] and Tank and Storvick,[4]

found primary teeth more resistant to dental caries with the administration of prenatal fluorides. Carlos, Gittelsohn, and Haddon,[5] and more recently Horowitz,[6] however, reported no observable anticariogenic benefits from prenatal fluoride administration. It seems to be the consensus, however, of the experts "qualified by scientific training and experience to evaluate the effectiveness of drugs"[7] that the evidence available to us today does not justify the administration of dietary fluoride to the pregnant or nursing woman for the control of dental caries. An excellent review of the prenatal administration of fluoride may be found in the September 1966 issue of the *Journal of Oral Therapeutics and Pharmacology.*

On Oct. 12, 1966, Dr. James L. Goddard, Commissioner of the Federal Food and Drug Administration, issued the following statement regarding prenatal fluoride preparations:[7]

> "(a) The Food and Drug Administration finds that there is neither substantial evidence of effectiveness nor a general recognition by qualified experts that prenatal drug preparations containing fluorides are beneficial to tooth development in the fetus or in the prevention of dental caries in the offspring.
>
> "(b) Any such drug preparation that is so labeled, represented, or advertised will be regarded as misbranded and subject to regulatory proceedings unless such recommendations are covered by a new drug application, including substantial evidence of effectiveness, approved pursuant to section 505 of the Federal Food, Drug, and Cosmetic Act."[5]

This Rule and Regulation in effect prevents the drug industry from advertising or advocating the use of prenatal supplements until such time as additional evidence is presented to prove their effectiveness.

The conclusion of the Food and Drug Administration was based on two considerations: (1) lack of concrete proof that fluoride passes through the placental barrier in sufficient quantity to be effective in the prevention of dental caries; and (2) realization that calcification of the teeth is mostly a postnatal function and those primary teeth prenatally affected by the dietary supplement are the least susceptible to decay.

Vitamin–Fluoride Supplement

The use of the fluoride–vitamin combination as a dietary supplement *cannot* be encouraged or recommended at this time for several reasons:

> (1) The difficulty involved in adjusting the fluoride allowance in accordance with the varying levels of water fluoride in many communities.[8] The dosage level of vitamins remains relatively constant, but the need for fluoride will vary depending upon the age of the patient and the level of fluoride present in the drinking water.
>
> (2) The lack of scientific studies to substantiate the effectiveness of the fluoride–vitamin in preventing dental caries. There have been only two studies, to our knowledge, reported in the literature which suggest that the fluoride–vitamin combination might be effective.[9,10] They claim highly significant reductions in the primary dentition, but insufficient time has elapsed to measure their effect upon the permanent dentition. Thus up to this time their use has been predicated strictly on presumptive evidence.
>
> (3) Based on the recommendations of the Committee on Nutrition of the American Academy of Pediatrics which question the routine administration of the vitamin supplement.[11]

Doctor Schlesinger, Assistant Commissioner for Special Health Services, New York State Department of Health, had this to say in commenting on the use of the vitamin–fluoride supplements:

> "The administration of fluoride–vitamin combinations to children is not justified by any scientific rationale . . . Certainly, multiple vitamin preparations are being widely abused, and the addition of fluoride to these preparations only multiplies the abuse."[12]

Topical Fluorides

Although it is the intention of this paper to deal only with the dietary fluoride supplements, brief mention should be made of the topical application of fluorides to the teeth. This method, which uses somewhat different application techniques depending on the agent employed, has a significant caries-prevention effect. This preventive effect, however, is considerably less than that of

community water fluoridation. Three solutions approved by the Council on Dental Therapeutics are in use today.[13] They are 2% sodium fluoride, 8% stannous fluoride, and an acidulated phosphate fluoride solution.

There seems to be ample evidence to show that fluoride dentifrices can provide some protection in the prevention of dental caries. Acting on this evidence the Council on Dental Therapeutics has classified several of the commercial fluoride toothpastes as effective agents in the control of dental caries.[14]

One cannot help but agree, in our opinion, with the Canadian Dental Association's advice that the use of a topical application of fluoride "may be advisable, either in conjunction with, or after the cessation of, systemic fluoride therapy in order to increase the fluoride concentration of the enamel surface."[15]

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FEMORAL HEAD PROSTHESIS FOR HYPERTROPHIC ARTHRITIS OF THE HIP

EUGENE J. NORDBY, MD and KENNETH M. SACHTJEN, MD, Madison, Wis.: *Clinical Orthopedics and Related Research* 57:191–202, 1968

Experiences with 53 private patients utilizing 60 femoral head prostheses in the treatment of advanced hypertrophic arthritis of the hip as followed postoperatively for 1 to 16 years are analyzed.

Seven of the 53 were bilateral cases, 28 females and 25 males. The average hospital stay was 24 days for each procedure.

No comparison is made with other methods, but the femoral head prosthesis is deemed most useful where the acetabular component is least involved. The indications for use of the femoral head prosthesis was the failure of symptomatic care—progressive stiffness and progressive hip pain.

Motion was always improved and although pain was not always completely relieved, it was changed in type to be more amenable to treatment. Night pain was always relieved.

X-ray findings that reflected probable clinical trouble included progressive migration into the acetabulum by bony absorption, absorption about the stem to give loosening in the shaft, excessive ossification about the acetabular margin or lateral capsule to mechanically decrease motion, and evidence of infection (one in this series). Presence of a "joint space" reflects a situation that almost insures an excellent result. Among the 53 patients 15 had a significant complication (28%) with a total of 19 complications occurring (31%).

Functional results are described by outlining activities of representative individuals and in roentgenographic studies. Functional results were assessed as excellent in 10%, good 25%, fair 52%, poor 5%, failure 4%, and deceased 4%.

Acetabular reaming or loss of articular integrity by acetabular fracture—dislocation permits migration of the metallic head as does the presence of abnormal bone in Paget's disease or radiation osteitis.

The use of femoral head replacement in avascular necrosis is deemed superior to other forms of arthroplasty. The more nearly Shenton's line is of normal configuration, the more likely is the mechanical condition suitable to good function in any prosthetic replacement.

The 7 cases with bilateral prosthesis could all walk without support, but with evidence of poor endurance and insufficient abduction power which gave a waddling element to the gait. One postoperative dislocation occurred because of too shallow an acetabulum; revision gave a good result. Three to six months interval was used between procedures in the bilateral cases.

It is concluded that this series shows the Moore femoral head prosthesis to be useful in retaining motion and decreasing pain in hypertrophic arthritis of the hip, the excellent result depending upon the integrity of the acetabular surface.

Therapeutic Dilemmas

No. 14 of a Series

Editor:

HARRY BECKMAN, M.D.

Houghtan Fellaw in Clinical Research and Cansulting Physician, Columbia Hospital

COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner monthly in the WISCONSIN MEDICAL JOURNAL.

SYSTEMIC LUPUS ERYTHEMATOSUS

Moderator: Richard D. Fritz, M.D.
Participants: Carl Saggio, M.D.
George C. Owen, M.D.
Frederick W. Madison, M.D.
Donald M. Ruch, M.D.
Edward Burg, M.D.
Mario de Oliveira, M.D.
Gerson C. Bernhard, M.D.
Miss Edith Volk

Dr. Richard D. Fritz: There is currently in the hospital a young patient whose plight has presented so many problems, and impelled so much consultation, that we have decided to consider the case here this morning to effect whatever resolution of the dilemma might come from group discussion. Dr. Saggio?

Dr. Carl Saggio (Intern): An 18-year-old white woman was admitted June 24, 1968, complaining of weakness, fatigue, and a skin rash. For one month prior to this time she had been under treatment by the family physician with penicillin and demethylchlortetracycline (Declomycin) for persistent pharyngitis and suspected infectious mononucleosis. She recalled that toward the end of this period she had sat in the sun for half an hour, and that this exposure preceded appearance of the rash by two days. The rash appeared first on the knees and then involved the face and arms; there was associated marked swelling and pruritus.

She complained of difficulty in swallowing coarse food throughout her illness and that there had been a 15-lb weight loss. Menstrual periods had been normal except for that which immediately preceded admission, which had lasted two weeks. Six months prior to admission she experienced swelling and pain upon flexion of the proximal interphalangeal joints. This gradually disappeared without treatment but returned with cold and damp weather.

She was an alert, well developed and nourished young woman who was extremely weak but not in acute distress at the time of my examination. Her blood pressure was 96/50 mm Hg; pulse 88/min. There was marked redness and swelling with hemorrhagic lesions on the face and neck with crustation present in the malar area. There was a milder degree of skin involvement on the neck, hands, arms and knees, with petechial hemorrhages on the face and arms. The eyelids were swollen. The posterior cervical nodes were enlarged. Otherwise, the findings on physical examination were essentially normal.

The hematologic findings were strikingly abnormal. Hemoglobin was 5.2 gm/100 ml; hematocrit 16%; red blood cell count 2.1 million; white blood cell count 4,800 cu mm with subnormal proportion of lymphocytes; there was one myelocyte and one metamyelocyte. The platelets were down to 9,000 and the reticulocyte count up to 10.2%. A bone marrow aspiration specimen was reported as "hypoplastic aplastic anemia secondary to possible drug therapy."

An L.E. preparation on the day of admission was negative, but three days later it became positive and has remained so. A venereal disease research laboratory (VDRL) test was positive but was offset by a negative fluorescent treponemal antibody (FTA) test.

Urinalysis values were strikingly variant on successive occasions: red blood cells from 3 to 5 per high-power field up to clumps; white blood cells from 2 to 20; hyaline casts from 5 to 8 and some granular casts in all samples; protein content ranged from 60 to 3,000 mg/100 ml.

Under treatment with flurandrenolone (Cordran) and Dermabase creams the dermatitis improved. Four days after admission a punch biopsy of the skin provided a diagnosis of acute systemic lupus erythematosus and the administration of prednisone (Meticorten, etc.), 20 mg three times a day, was begun immediately. About three weeks later there began episodes of irrational behavior that will be described by others.

Dr. Fritz: Thank you, Dr. Saggio. Dr. Owen, will you describe your early experience in the case?

Dr. George C. Owen: This girl was desperately sick when I encountered her in the Outpatient Department. I had her admitted and at once began the requests for help from other members of the staff; requests for help

are continuing. The first grave problem that confronted us was to account for the severe anemia, for which I turned to Dr. Madison on the morning of admission.

Dr. Fritz: Dr. Madison?

Dr. Frederick W. Madison: Initially we had to seek explanations for a pancytopenia coupled with a rash of an obvious photosensitivity type. One of the drugs she had been taking, Declomycin, is a known photosensitizer. And of course the possibility of systemic lupus erythematosus (S.L.E.) had also at once to be considered. It took several days to clarify this situation.

It is of interest that the first diagnosis of S.L.E. in this community was made at this hospital many years ago, shortly after the appearance of Klemperer and Baehr's pioneering paper (G. Baehr, P. Klemperer and A. Schifrin. *Tr. Assoc. Am. Physicians* 50:139, 1935), which incidentally did not include hematologic observations. When Hargraves described the L.E. cell and the "tart" cell (M. M. Hargraves et al. *Proc. Mayo Clinic* 23:25, 1948), I think that none of us at once appreciated their clinical significance. It is only as the years have passed that the picture has developed fully.

We have recognized the importance of anemia, of the pancytopenias that often occur, of the hematoxylin body, and certainly of the L.E. cell, which has become one of the important diagnostic criteria. In fact we now hesitate to make the diagnosis of S.L.E. in the absence of L.E. cells.

The bone marrow is usually a little more exciting than it was in this case. There are usually considerable alterations and the increased production of plasma cells, which are responsible for the striking immunologic abnormalities that are the hallmark of the disease. I think we have tended to neglect the bone marrow somewhat in this disease, but it is worthwhile recalling that Hargraves' original observations of the L.E. and tart cells were made in the bone marrow, not in the peripheral blood. Today we are depending entirely upon peripheral blood studies to reveal the L.E. cell.

Thirty years ago this was an inevitably fatal disease, but fortunately we have learned to deal with it somewhat more effectively in recent times. As you all know, we don't quickly lose all of these patients nowadays; many of them are still around, not always as healthy individuals, but they are still here.

Dr. Fritz: Dr. Ruch saw the patient from the dermatologic standpoint. Dr. Ruch?

Dr. Donald M. Ruch: By the time I saw this patient in the evening of the day of admission I was at least the fifth person who had examined her and she was a little bit fatigued. But when we had her sit up in bed, the immediately striking feature of her dermatitis was its limitation to the exposed areas of the body—the face and neck, with sharp margination posteriorly, and the v-chest; it faded a great deal at the sleeve line and on the thighs.

She had been wearing culottes on June 1, the day she had been out in the sun for 30 to 45 minutes. She had been wearing sun glasses that day, too, and the area around the eyes was free of eruption; there was also some freedom under the jaw. There were some unroofed vesicles on the knees and some streaks there as if she had been applying tanning lotion. It was obvious that there was also a superimposed contact dermatitis.

The slide (Fig 1) is a face-frontal view on the third day of admission. We did not find the heliotrope eyelids that one sees in the endogenous photosensitization eruptions of dermatomyositis. We thought of and ruled out pellagra and also porphyria cutanea tarda.

It seemed obvious that there was more here than the probable S.L.E. accounting for the photosensitivity. I found it very interesting that she had been exposed to the sun for 30–45 minutes on June 1 and developed the knee blisters on the next day. Then the severe dermatitis developed a week before she came into the hospital. So there was a time lapse of about two weeks between exposure and full-blown development of the eruption. She was in the habit of using Dial soap, which contains hexachlorophene, a photosensitizer. The family also provided the Declomycin history—she had been on the drug from May 25 to June 3; and Declomycin is also a photosensitizer. There had been penicillin medication from May 10 to May 24, and then again from June 4 to June 20—but penicillin has not been known to cause photosensitivity except in one reported case, in which the patient was also using a photosensitizing soap.

On the fourth hospital day I did a skin biopsy of the right lateral upper arm, which showed acute S.L.E. But I believe this patient also had a phototoxic reaction to Declo-

Figure 1

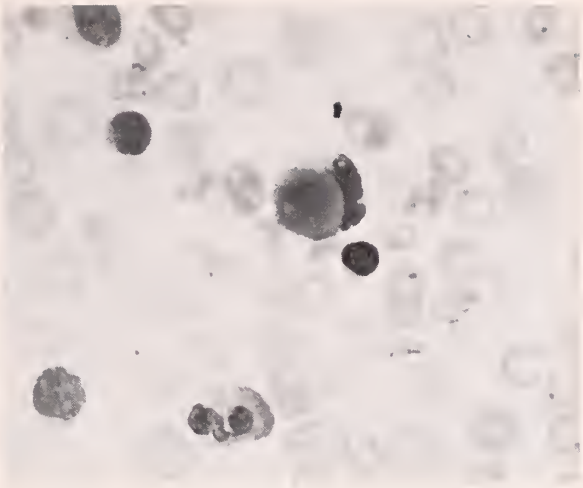

Figure 2

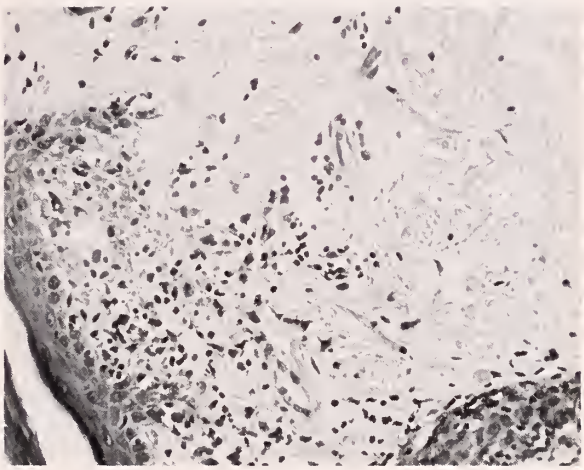

Figure 3

mycin and an allergic reaction to the Dial soap.

Dr. Fritz: Dr. Burg, you have slides to show?

Dr. Edward Burg (Department of Laboratories): The first slide (Fig 2) depicts the L.E. cell in the peripheral blood of the patient. It shows the nuclear inclusion—the altered nuclear material within a polymorphonuclear leukocyte. The nuclei of the polymorph have been pushed to the periphery of the cell by the inclusion body, providing the classical L.E. cell.

The classical findings in the skin biopsy in L.E. usually do not manifest fully under about four weeks. I therefore show you a slide (Fig 3) from a patient somewhat more advanced in the disease than our present young lady. What we find here are a liquefaction degeneration or necrosis at the epidermal–dermal line; a rather marked edema in the connective tissue network; extravasation of erythrocytes from the smaller vessels; fibrinoid changes within the collagen tissue; and frequently (though not visible in this slide) a mucoid degeneration of subcutaneous fat, with sometimes a fibrinoid change in the smaller vessels. The next slide (Fig 4) is from the present patient, in whom the changes are not yet so profound, although they are compatible with a diagnosis of acute L.E. The last slide (Fig 5) shows a hematoxylin body, which is another point favoring the diagnosis of acute L.E. in this instance.

Dr. Fritz: Is there a report from the laboratory on the antinuclear factor that will be discussed by Dr. Bernhard?

Miss Edith Volk (Department of Laboratories): Fortunately this type of study became available on a service basis in our laboratory just before material was provided from the present patient. We found a ringed pattern of fluorescence suggestive of anti-

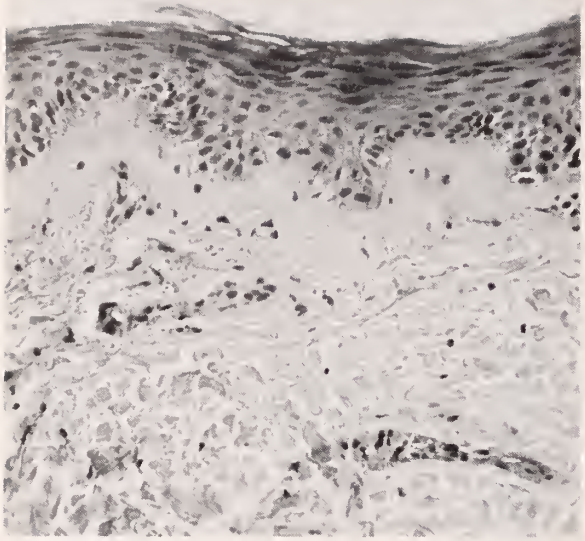

Figure 4

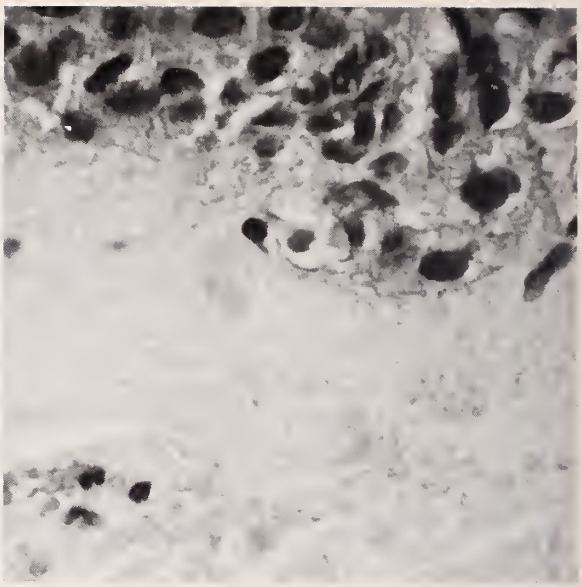

Figure 5

DNA factor. A finding of this sort is not fully diagnostic of L.E. because it may be had in some of the dermatoses and in some forms of hepatitis, but in this case it certainly had confirmatory value.

Dr. Fritz: Dr. Owen, do you want to discuss further the patient's progress?

Dr. Owen: On 60 mg of prednisone daily she was doing very well. Four units of blood at the outset had restored her hematologically and she complained only, through Dr. Ruch's bandages, that she was gaining weight, which indeed she was. There was of course the usual prednisone euphoria. We put her on the reduction diet and low-salt intake that appeared indicated. Urinalyses showed marked improvement in albumen and cellular content and the BUN fell from 36 to 17 mg/100 ml.

Then one night she awakened with a sensation of impending death, was very agitated throughout the remainder of the night, and called her family in a very upset state the next morning. We, and they, sought to calm her down, thinking this was only the reaction of an 18-year-old girl who had been sick for a long time. But unfortunately it was actually the prodrome to a very severe and overwhelming psychosis which had schizoid features and was very harrowing to watch. This confronted us with a very real therapeutic dilemma: should we decrease the prednisone on the assumption that we were seeing a prednisone psychosis, or should we recognize a lupus erythematosus psychosis here and hence increase the prednisone dosage? We called upon Dr. de Oliveira for help at this point.

Dr. Mario de Oliveira: The patient had been on corticosteroids for one month when I saw her for the first time on July 18. She was restless and was having florid hallucinations. She felt that she was pregnant and that I was the doctor who was to deliver her of the devil, which was obvious patterning after a recent motion picture. Then in a second phase she thought that I was the doctor whose daughter was a close friend of hers, and finally she recognized me for myself. At times she not only felt that she was pregnant but that she had a penis also, and sometimes she used profane language. Her memory was not severely impaired and I was unable to find any neurological deficits.

Most of the psychiatric features of this patient's state were those of a schizophrenic reaction. She did not have any of the so-called organic mental symptoms: confusion, disorientation, changes in intellectual functions, short attention span, inability to perform simple calculations or to deal with abstraction. I therefore thought that the condition was probably one of corticosteroid-induced psychosis. However, there is evidence in the literature (M. Stern and E. S. Robbins. *Arch. Gen. Psych.* 3:205, 1960; J. F. O'Connor. *Ann. Int. Med.* 51:526, 1959; J. F. O'Connor and D. M. Musher. *Arch. Neurol.* 14:157, 1966) that a psychiatric reaction to corticosteroid therapy occurs in only about

5% of patients who do not have S.L.E. whereas between 30% and 50% of all patients with S.L.E. develop psychiatric complications regardless of the type of therapy that is being employed. For example, in the 152 patient series of O'Connor and Musher, 52 became psychotic and 24 of these were not on corticosteroids or became psychotic before such therapy was instituted. These observers felt that severity and chronicity of the disease were the two most important factors in the development of these psychoses.

Nevertheless, I recommended gradual reduction of the medication, which was carried out (she is currently receiving only 15 mg of prednisone daily), and have not seen evidences of further advancement of the mental symptoms; in fact, the patient's present psychiatric status is much improved.

Dr. Fritz: At one time in the course of our consultations in this case, the question of giving the patient azathioprine (Imuran) arose. Dr. Bernhard will review the subject of the use of immunosuppressive agents in this disease on the basis of a study he is conducting at another hospital.*

Dr. Gerson C. Bernhard: This disease is partially controllable by therapy. Many patients who would formerly have died early of acute lupus crisis or infection can nowadays be gotten past that point. But they then reach a stage of renal involvement. I believe that this young lady had S.L.E. developing some months before she was given Declomycin, because there is a history of polyarthritis and polyarthralgia of mild degree beginning in December. The other manifestations that brought her to diagnosis followed much later. By the time she reached the hospital the kidneys were already significantly involved in the process, as revealed by the cells and casts in the urinary sediment. It was then my suggestion that Imuran might be helpful.

Ever since Hargraves' demonstration of the L.E. phenomenon, we have known that there are circulating antibodies in S.L.E. that are apparently directed against the nucleus or some fraction of it. Immunofluorescence studies of the type Miss Volk reported upon point toward the presence of an anti-DNA antibody. In fact one can follow the course of the disease fairly well by the titer of this antibody. Accumulating evidence appears to involve other antibodies also; for Dixon and also Tan (F. J. Dixon. Sympos. Immunopath., 1967, Schwabe & Co., Basel, 1968; E. M. Tan. *J. Lab. & Clin. Med.* 70:800, 1967) have shown that immune complexes with a fraction of complement can be found in the kidneys of patients with lupus nephritis. Similar complexes can be demonstrated in the skin. Whether this complement-binding is truly an antigen-antibody affair or merely the reflection of increased gamma globulin aggregation that binds complement, is not known. In any case, serum complement titer generally drops during acute lupus nephritis.

These evidences of immunologic occurrences in the disease have directed attention toward the possibility of controlling the situation through the interfering action of such immunosuppressive agents as are used in treating certain of the malignancies. Of course a supporting reason for considering resort to such measures has been the doubtful efficacy of corticosteroid therapy in lupus nephritis. I believe that, despite Kark and Pollak's data (V. E. Pollak, C. L. Pirani and R. M. Kark. *J. Lab. & Clin. Med.* 57:495, 1961; V. E. Pollak et al. ibid. 63:537, 1964), the evidence is not clear that the advancement of this complication of the disease can be blocked by even high dosage of the corticosteroids. Of course if one grants that the immunosuppressive action of the cytotoxic agents is exerted only to prevent antibody production at the induction of a primary response, then it must follow that the use of such agents is irrational in lupus nephritis, for when this diagnosis is made the damage—the immunologic event—has already occurred. However, if one postulates a succession of such events with anamnestic responses, then it becomes rational to attempt to block these successive occurrences with the drugs, and thus prevent the development of cytotoxic immune complexes.

This is the approach we have been making in the study at our hospital, to which Dr. Fritz referred. We have been treating patients with lupus nephritis with Imuran either alone or in combination with corticosteroids. So far we have been taking patients into the study in any stage of the disease and irrespective of the nature of their prior therapy. The series is still small and we hope to be able to add considerably to it when the knowledge becomes general that such a study is going on. Eight of our 10 patients

* Milwaukee County General Hospital.

have gone long enough to provide us with a modicum of information at least.

We find that when serum complement titers have been low initially, they have invariably risen to normal levels on the Imuran treatment. We have also seen proteinuria decrease slightly. Skin lesions have sometimes disappeared also, as well as arthritis, fever, and general toxicity. Renal biopsy evidence has been difficult to interpret because a much larger number of cases will be required to make valid our comparisons with the normal untreated course of patients. And it has been difficult, too, to assess the significance of our ability to lower corticosteroid dosage in some of the cases—might we have been able to do this without the Imuran? We do feel confident, so far as we have gone, that severely afflicted patients who have had their disease for a relatively long time and are in a rapidly progressive state are not materially affected by either corticosteroids or Imuran, alone or in combination. In one of our young patients, for instance, the nephritis scarring progressed so far, despite therapy, that kidney transplantation became necessary.

Of course there are serious complications of Imuran therapy. One is bone marrow suppression, and the fact that leukopenia is often also a feature of S.L.E. without therapy of this sort often makes it difficult to know precisely with what one is dealing in the presence of this finding in an Imuran-treated patient. A second serious occurrence is infection. But infection complicates high corticosteroid therapy also, as is well known. I doubt that the patient on Imuran is at any greater risk in this regard than the one on corticosteroids.

Our study has advanced to the point that it is now incorporated in a multi-center trial of Imuran therapy in which we will concentrate on patients who are early in their disease—individuals, such as the young lady we have been considering today, who present themselves in a florid state, preferably with kidney involvement, and untreated previously. We will achieve double-blind conditions as nearly as possible and hope to learn within a few years whether immunosuppressive therapy has merit.

Dr. Owen: Since there is some recent evidence (P. H. Schur and J. Sandson. *New Eng. J. Med.* 278–533, 1968) suggesting that the anti-DNA antibody rise and sharp fall in complement may antedate clinically recognizable events in this disease, I should like to ask Dr. Bernhard whether he feels that a point of importance in practical management of the cases will emerge from this? We need that kind of evidence here, for this patient gives every appearance of being clinically well today.

Dr. Bernhard: I think that this is possible, at least so far as progress of the renal involvement is concerned. But we are not so sure that these things so definitely reflect impending complications of other types, or their progression.

Dr. Fritz (summarizing): I think we can make the claim for this morning's conference that it has at least fully exposed the problems that can be encountered in systemic lupus erythematosus, whether or not it has really presented definitive evidence that very effective therapy is available at present.

BOOKLETS FOR COLOSTOMY. ILEOSTOMY PATIENTS

Patients facing a colostomy or an ileostomy have many fears and questions that are not easily expressed. Two new booklets are available to help smooth the patient's adjustment both before and after surgery—*Living Comfortably with Your Colostomy* and *Living Comfortably with Your Ileostomy.*

The publications can be used as teaching aids by physicians and nurses working with ostomy patients. They also are informative for professional personnel themselves.

Author is Darlene Larson, R.N., who has had extensive experience with ostomy patients. The booklets are based on this background and on training received at the Cleveland Clinic.

Development of this material was made possible under Grant RT-2 of the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare, awarded to the Department of Physical Medicine and Rehabilitation of the University of Minnesota Medical School and the Kenny Rehabilitation Institute.

Single copies are 75¢. Orders to: Publications, American Rehabilitation Foundation, 1800 Chicago Ave., Minneapolis, Minn. 55404.

* * *

WE HAVE FOUND THAT many physically handicapped people have exceptional perseverance. Their strong will to succeed provides job opportunity for them as it would for anyone. We will continue to need and use their skills. . . . G. L. Phillippe, chairman of the board, General Electric Company.

W. D. James, M.D.

PRESIDENT'S PAGE

Continuing Education—A Must

VITAL NEW MEDICAL DISCOVERIES are of little use against human disease until the physicians engaged in active practice learn about them. No matter how well prepared a physician may be when he enters practice, the adequate knowledge of yesterday is not fully adequate today. Among the means of keeping abreast of the advances in medical science are reading professional literature, consultations with colleagues, staff conferences, and local, state, and national meetings. There also are formal postgraduate courses and regional hospital–medical school educational programs.

Continuing education programs must augment and modify initial training no matter how adequate that training may have been. This is important for two reasons: Not only does participation in these programs increase the knowledge and skill of the physician but also it serves to reassure the patient that he is getting the best possible care that the medical profession can offer. Faith in the knowledge and skill of his doctor is vitally important to the well-being of the patient. It also is important to the well-being of the medical profession.

How then can we motivate our members to take advantage of the many educational opportunities available to us? Does motivation need to take the form of penalties or rewards? One state medical society has made continuing education a requirement for maintaining membership. Another state has made it a prerequisite for payment for work done under Title 19 authorization. The AMA Council on Continuing Education is planning to set up a system of awards for completing a definite number of hours of prescribed training in an accredited institution.

In Wisconsin we are unusually blessed with opportunities for advanced training. Courses for that purpose are offered by both of our medical schools. The State Medical Society sponsors teaching programs in various parts of the state throughout the year, and teaching seminars are offered by the specialty groups.

Much thought and effort is being expended to make these programs valuable and interesting to practicing physicians. However, participation in them is left to the initiative of the individual. It is better by far that we avail ourselves of these opportunities on a voluntary basis rather than under the threat of reclassification requirements.

As we look ahead to the New Year, I express my hope that every Wisconsin physician will include in his plans some time for his own continuing professional education—and I extend to each of you my personal best wishes for a happy and prosperous New Year.

W. D. James M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

DECEMBER 1968
Vol. 67 No. 12

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Blue Foundations

■ MORE THAN A FEW informed observers have questioned whether the constantly increasing cost of hospital care could be confronted by anything other than an increase in price to the patient. Lone voices have pointed out that private business constantly strives for operating efficiency and greater productivity so that the cost of its product can be kept as low as possible for competitive reasons.

Without the spur of competition, hospital administrators have often transmitted cost increases to the patient, institutionalizing inefficiency, extravagance, and antiquated procedures. After all, as long as the patient, or his insurance carrier, would pay the price demanded, why worry about keeping it down?

At long last, however, the federal government and the Blue Cross Association indicate they are conscious of the possibility that price increases in hospital care are not inevitable. Blue Cross of Western Pennsylvania has recently announced that it was awarded a $105,000 contract to undertake a program of research into management techniques and hospital reimbursement incentives. The object: to improve cost controls in hospitals.

The project provides for a study lasting 21 months during which experienced management consultants will conduct an investigation of operating procedures in carefully selected hospitals. They will then recommend and implement cost savings programs in cooperation with hospital administrators. Hopefully, the study will develop means to stabilize or reduce the price of hospital care without sacrifice of its quality through the application of business practices used by private enterprise.

Walter J. Mc Nerny, president of the Blue Cross Association, stated that the project reflected the interest of Blue Cross in helping to improve the productivity of hospitals, by holding to criteria of performance calling for efficiency and effectiveness in their procedures. Considering that Blue Cross has 64 million subscribers and administers programs for Medicare, it is an encouraging sign that this cost-reducing program is undertaken, and the organization should be applauded for this long awaited effort.

Of equal interest is the manner in which the project is undertaken. The U.S. Public Health Service through its Bureau of Health Services awarded a prime contract of

$117,050 to the Health Services Foundation of Blue Cross. The Health Services Foundation, in turn, engaged Blue Cross of Western Pennsylvania as the subcontractor to carry out the actual field work. The choice of the Foundation, a research and educational function of the Blue Cross Association, is a happy one, since there is probably no organization that has greater familiarity with various hospital methods or that has easier access to all departments of a hospital. The Health Services Foundation could achieve a result of great value to hospitals across the country as well as to present and future hospital patients.

The advantages of a research arm for the Blue plans should be obvious, and, happily, the Board of Directors of the National Association of Blue Shield Plans has recently authorized the establishment of a Blue Shield Foundation. This Foundation will be available for scientific, educational, and research programs, apart from the applied economic and systems work of the NABSP. It will permit Blue Shield to qualify under the internal revenue code as the recipient of grant funds for special projects, both from the government and from private donors, with full tax deductibility for the latter.

With the establishment of the Blue Shield Foundation, we may now expect a systematic, organized examination of the providence of medical care with a view toward holding the line on its cost. The existence of such research foundations for Blue Shield, as well as Blue Cross, means we can look forward to more sophisticated, more efficient, and more economic health care service in this country. The fact that allied health care organizations have established such research organizations proves false the charge that we are indifferent to the economic aspects of health care and that we have to be dragged kicking and screaming to face the realities of present day society.—D.N.G.

LETTERS

NURSES GROUP APPRECIATES CONCERN

To the EDITOR:

The following resolution was adopted by the House of Delegates of the Wisconsin Nurses Association at its closing session held at the Sheraton–Schroeder Hotel, Milwaukee, Oct. 11, 1968:

> "That at the close of the annual meeting of the Wisconsin Nurses Association we extend our sincere thanks and appreciation to the entire news media throughout the state for the publicity given the convention and for their articles and editorials which have appeared periodically throughout the year, informing the public of nursing's needs and concerns."

WNA staff is especially grateful for the fine coverage provided by the official organ of your association. We were pleased with the format used in presenting this information to your membership.

(Mrs. Logan) Alice A. Weldy, R.N.
Executive Secretary
Wisconsin Nurses Association, Inc.

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

"PUBLISH OR PERISH"

To the EDITOR:

"Publish or perish." So why perish, when one can publish? And publish we do.

The situation is akin to the weather: everyone complains but no one seems to know what to do about it. I don't either. But, even if I do not have a solution for it, it helps in some way to outline the magnitude of the problem.

Based on the above assumption (and partly for my own amusement), I took the liberty of tabulating all of the material received in my office for the one month of July 1968—carefully excluding specific drug literature. Despite the outraged cries of my secretary, the material was categorized as follows:

(1) Subscription (i.e., material that I had sought)

(2) Organizational publication (i.e., material that arrived because I belong to a specific organization)

(3) Unsolicited (i.e., material that just arrived)

It is ironic that I should have to submit this material to one of the journals on the list, but I should imagine that your sense of fair play (and perhaps for your own amusement) would direct you to include this compendium in one of your out-of-the-

way pages. Perhaps my colleagues will feel better when they assess the magnitude of the problem.

CARL J. LEVINSON, M.D.
Milwaukee

(EDITOR'S NOTE: Doctor Levinson's list appears below with the number of pages in parentheses. A query to Doctor Levinson as to whether he read all the publications revealed that he "*scanned* each and every one. Where I found some substance, I took time to delve in. It isn't easy, but it does keep me current.")

JOURNALS RECEIVED IN A PHYSICIAN'S OFFICE DURING MONTH OF JULY 1968

I. SUBSCRIPTION—Total pages: 487

International Correspondence Society of OB-GYN, 2 issues (16 pages); New England Journal of Medicine, 4 issues (220); Obstetric and Gynecology Survey (108); Obstetrics and Gynecology (143).

II. ORGANIZATIONAL—Total pages: 1,341

Wisconsin Medical Journal (116); AMA News, 5 issues (66); New York University Alumni News (8); American Association for Maternal and Child Health (24); Archives of Internal Medicine (96); J.A.M.A., 4 issues (726); LAB Newsletter [Wisconsin] (12); American Journal of Obstetrics and Gynecology, 2 issues (285); American College of Obstetrics and Gynecology (8).

III. UNSOLICITED—Total pages: 2,605

Medical Tribune, 9 issues (240); Rx Golf & Travel (43); Lying-in (100); Modern Medicine, 3 issues (364); Medical World News, 4 issues (330); MD (240); Current Medical Digest, 2 issues (192); Advances in Fertility Control (32); Medical Opinion and Review (113); Medical Economics, 2 issues (376); Hospital Practice (64); Obstetrics and Gynecology News, 2 issues (80); Hospital Medicine (66); Physicians Management (120); Ortho Panel No. 1 (16); Child and Family (96); Obstetrics and Gynecology Digest (72); Human Sexuality (53); The Family Planner (8).

TOTAL PAGES of all the publications: 4,433

MINUTES OF COUNCIL MEETING

MACKINAC ISLAND, MICHIGAN, JULY 19, 1968

The meeting was called to order by Chairman Nordby at 2:15 p.m. with the roll call showing the following in attendance: Doctors Schulz, Nordby, Carey, McRoberts, Rohde, Boren, Manz, Van Hecke, Egan, Chojnacki, Hollenbeck; Past President Kief, President James, Speaker Behnke, President-elect Callan; AMA delegates or alternates Bell, Galasinski, Fox, and Picard. Staff and others present were Messrs. Crownhart, Reynolds, Brower, and Maroney; Mrs. Anderson; and AMA Field Representative Leon J. Swatzell.

Councilors absent were Doctors Bayley, Stoops, Huth, Sisk, Dettmann, Grand, Houghton, Sullivan, and Wright.

1. Proposed Appointments of Council Chairman to Commission on Wisconsin's Health and Natural Resources

Doctor Nordby indicated some names had already been suggested to him, and others were added during the discussion which followed. The Commission calls for nine members. As nearly as possible the terms of one-third of the members shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two and three year terms. Seventeen names were suggested, and it was clarified that membership of this Commission, including the chairman, is by appointment of the Council chairman.

2. Proposed Appointments of Council Chairman to Committee on Medicine and Religion

Eleven names were suggested to Chairman Nordby for membership on this committee. It is the privilege of the Council chairman to determine the number of members, representing the various faiths, and to make appointments including that of its chairman.

3. Nominees for State Division of Health Councils

Nominations were suggested for appointment by the State Division of Health to its Council on Hospital Construction and its Council on Nursing Homes. The suggestions will be forwarded by the staff.

4. Division on Aging, Commission on State Departments

On motion of Doctors Van Hecke–Boren, carried, Craig Larson, M. D., was appointed chairman to fill the vacancy created by the death of Doctor Stebbins. Doctor Larson has been a member of the division which may select its own additional member.

5. Wisconsin Regional Medical Program, Inc.

On motion of Doctors Chojnacki–Manz, carried, Frank E. Drew, M. D., Milwaukee, was reappointed as the Society representative on the board of directors.

6. Voting Privileges for Resident Members

It was suggested that all privileges of membership be extended to resident members in order to encourage interest in the activities of organized medicine

and to bring to them current concepts. Primarily affected would be Dane and Milwaukee counties. The privileges would include the right to vote, to hold office and committee membership, and would require House of Delegates action to change the constitution and bylaws.

On motion of Doctors Chojnacki–Carey, carried, the proposal was referred to the Planning Committee of the Council for its recommendations.

7. SMS House of Delegates Actions, May 1968

Doctor Nordby reviewed actions of the House in which items were referred to the Council or its committees for study or recommendations:

(a) Reference Committee, Reports of Officers

Comprehensive Health Expenditure Commission (CHEC) and the item regarding special consultants to research and report the true picture of health costs to the public were referred to the Committee on Economic Medicine, on motion of Doctors Behnke–Boren, carried.

By general agreement, the item regarding the use of sophisticated telephone equipment to accommodate inquiries from physicians and communications media was referred to the staff for research on cost. Findings are to be reported back to the Council.

(b) Reference Committee, Reports of Standing Committees

Doctor Nordby noted the recommendation of CHRME regarding development of liaison with the nursing profession, including legislation, to increase the availability of nurses. Since the "project" has already been undertaken by Comprehensive Health Planning, it was recommended that a report be sought from medical members of CHP for report to the Council.

(c) Reference Committee on Resolutions

Resolution L re E-coli swimming water contamination tests. Doctors McRoberts–Chojnacki moved to direct formal transmission of the recommendation to study to the Council on Health, carried.

Resolution J by the Section on Pathology regarding recognition of consulting physicians. Doctors Van Hecke–Kief moved to direct formal transmission of the recommendations to the Council on Health, carried.

8. Comprehensive Health Planning and Wisconsin Regional Medical Program

Doctor Callan was privileged to offer his observations concerning recent activities in the realm of Comprehensive Health Planning. He indicated he was disturbed by an often-stated opinion that "medical care is deficient in quantity and quality, and too expensive in addition . . ." He indicated it was his understanding that the Wisconsin Regional Medical Program was considering some 60 projects involving the categorical diseases and expressed concern that some of the proposed programs would be a departure from the intent of Public Law 89.239. He expressed his belief that a higher degree of coordination might be achieved through comprehensive planning. Additionally, he stated that in his opinion the provision of medical care and its financing could not be separated.

Doctor Callan suggested that consideration be given to a special mechanism which would call for meeting regularly and keeping physicians informed with respect to the Regional Program and Comprehensive Health Planning. His recommendation was based on his observation that the physicians who served on these programs did not communicate with each other sufficiently. This should be corrected and there should also be a continuing process of providing information to the Council.

Doctor Egan identified some 17 physicians involved in varying degrees of regional and comprehensive activity and suggested that these be contacted and asked to report to the Council.

Doctor Van Hecke concurred in the concern expressed by Doctor Callan, and commented that the number of physicians involved when the various study groups are included was far in excess of 17.

It was then moved by Doctors Egan–Kief, carried, that the members of the State Medical Society who are involved with the Regional Program and Comprehenisve Health Planning be invited to meet with the Executive Committee of the Council in closed session to report in depth to the group. The motion included the instruction that the Executive Committee report its findings to the Council.

Subsequently a meeting date of August 17, 1968, at 1:00 p.m., was set and in preparation for the meeting, the staff was requested to prepare summaries of the five reports referred to in the May issue of HAPC Reports.

9. AMA Report on Financing Health Care for Persons Under 65

Dr. Galasinski referred to the AMA June report of the Council on Medical Services regarding the subject of Health Care Financing for persons under age 65. He first of all expressed appreciation on the part of the American Medical Association in recognizing that the impending impact of Health Care Financing for persons under age 65 was recognized by the American Medical Association as a vital matter which will have to be dealt with in the future. Therefore, in anticipation of this for once the American Medical Association was making a positive study in this type of health care financing so it could for once be on the positive side of directing the thinking in this particular matter. Doctor Galasinski further mentioned that a study was being made concerning such health care financing which suggested the principle of income tax credit against the individuals' health care insurance premium cost on a graduated scale.

Since this is but a report given for information purposes only and will be further studied and given as a report at the Clinical Session in December 1968, Doctor Galasinski wished to bring this to the attention of the members of the Council of the State Medical Society so that they would also bear this in mind in conferring with the Commission on Medical Care Plans so that all parties could benefit and contribute towards the direction of this positive thinking.

Doctor Nordby indicated that the Commission on Medical Care Plans was already working on recommendations which would be discussed at the joint meeting on July 20.

10. Adjournment

There being no further business, the Council adjourned at 4:45 p.m.

Respectfully submitted,

C. H. CROWNHART
Secretary

Approved:

E. J. NORDBY, M. D.
Chairman

MINUTES OF JOINT MEETING

COUNCIL AND COMMISSION ON MEDICAL CARE PLANS

MACKINAC ISLAND, MICHIGAN, JULY 20, 1968

1. Call to Order and Roll Call

The meeting was called to order at 9:45 a.m. by Council Chairman Nordby at the Grand Hotel.

Voting members of Council present: Doctors Schulz, Nordby, Carey, McRoberts, Rohde, Boren, Manz, Van Hecke, Egan, Chojnacki, Hollenbeck, Past President Kief, President James, and Speaker Behnke; also President-elect Callan; AMA delegates and alternates Bell, Galasinski, Fox, Picard, and Collentine.

Commission on Medical Care Plans: Doctors Carlson, Casper, Curran, Dessloch, Doyle, Garman, Goldstein, Mason, Mauthe, Rueckert, Simenstad, Smith, Sprague, and Wolf.

Staff and consultants: Messrs. Crownhart, Thayer, Koenig, Reynolds, Brower, Maroney, Murphy, Kluwin, Tiffany, Gill, and Cameron; Mrs. Anderson and Miss Pyre.

2. Announcements

Councilors were asked to reserve the weekend of October 18–20 for an Executive Committee and Council meeting, and the Excutive Committee was reminded of the date of August 17 for its meeting with representatives of the Wisconsin Regional Medical Program and Comprehensive Health Planning.

3. Report of Commission on Medical Care Plans

The joint meeting was requested for a report by the Commission on two subjects:

A. Central Wisconsin Surveys and Pilot Health Insurance Program

Mr. Thayer presented all information available to date on the broad subject on which numerous conferences have been held with representatives of the Marshfield Clinic, Sentry and Employers Insurance, area county medical societies, and the Wisconsin State University—Stevens Point.

He described two surveys to be conducted in the area with federal funding—an OEO household survey to determine "how much health service is required and how much is being received in the target area," and an HEW professional survey, details still unknown.

In reference to the surveys, the Commission recommended that staff continue to participate and attempt to eliminate inappropriate wording in the OEO questionnaire and to improve health insurance questions; advise all physicians in the area of the impending surveys in as much detail as is available, urging them to become directly interested in planning the HEW professional survey; obtain survey results as soon as available and be prepared to advise with physicians on any indicated response; assist physicians in the area in formation of one or more Comprehensive Health Planning Councils; and devote the August Green Sheet in the *Wisconsin Medical Journal* to this subject.

Mr. Thayer also reviewed the status of discussions regarding a pilot project of comprehensive health insurance, with federal subsidy, for the under- or uninsured in the area. Meetings to date have not resulted in the development of a definite proposal as to benefits, eligibility, etc., and the Society will host a meeting later in the month with the two insurance company participants, and with physician representation in attendance.

The Commission again recommended continued participation in these discussions and has concurred with staff on elements the Society should seek to incorporate in any pilot project, as follows:

(1) Clear definition of the geographic area to be served and the persons who are eligible for the benefits to be offered under the program.

(2) All insurance companies licensed by the Wisconsin Insurance Department shall be eligible to participate in the program.

(3) The personal and confidential relationship of patient to physicain shall be retained.

(4) Quality of medical care provided under the project shall continue to be the responsibility of physicians, and the promotion of the highest possible quality of care and standards of service shall be accomplished through the cooperative efforts of individual physicians, county and state medical societies and the insuring agencies.

(5) The patient shall have free choice of physician, dentist, pharmacist or other provider whose services are prescribed by the physician.

(6) All matters relating to medical practice should be determined by the medical profession; there shall be no interference with the practice of medicine.

(7) The concept of "customary, usual and reasonable fees" shall be utilized in the project since it provides the greatest degree of flexibility in meeting the needs of the patient. The State Medical Society of Wisconsin will assure the exercise of certain responsibilities on the part of medicine which are inherent in the successful application of this concept.

(8) A "minimum" benefit structure shall be established and will be required to be offered by any company electing to participate in the experimental project.

(9) Direct payment shall be made to physicians for their services.

(10) Provisions should be sought to protect the "insured" against loss or reduction of insurance benefits in the event the pilot project is terminated.

(11) The premium rates utilized by any participating insurance company shall be of their own determination, thereby seeking a natural competitive level.

(12) Governmental subsidy, if deemed necessary to the project, should:

(a) be directed to the insured rather than to the insuring agency or the physician.

(b) be made for those who have *need* for such assistance in the payment of health care costs or insurance premiums; i.e., based on ability to pay.

(c) utilize the concept of income tax credit along the general lines proposed by the AMA in June 1968 as a means of qualifying the proposed insured for government subsidy.

Following a period of open discussion, the Council, on motion of Doctors Van Hecke–Schulz, carried, extended such authority to staff as may be necessary to keep in contact with these projects to the extent possible, and requested further reports be submitted to the Council for decision on philosophical issues.

B. Postpayment Plan

Doctor Dessloch advised the Council of the Commission's authorization of an experimental program of postpayment, utilizing the credit card device, to help subscribers in the payment of uninsured health care expenses at reasonable cost.

Mr. Tiffany discussed the advantages of the plan as developed by the WPS consultants. He said that there is an ever-growing demand for more complete medical care coverage through the insurance mechanism, and at the same time an insistence on more efficient use of the premium money. The consultants believe that the combination of broad prepayment coverage accompanied by the postpayment card will make needed benefits available, within the ability to pay, without encouraging over-utilization or frivolous use of the coverage. The basic thesis is that first-dollar coverage, without subscriber involvement in the cost, produces greater claims cost than less complete coverage. It is intended that the credit standing of applicants within a group will be underwritten, and while benefit limits have not yet been defined, the card holder will obtain professional or other services not covered by WPS contract from providers who agree to the plan.

Question was asked whether the mechanism will be available for individual subscribers, and Mr. Tiffany said it would be tried first in a few areas with groups where there is broader underwriting protection.

There being no further discussion, President James, then acting chairman, asked if there was any other business.

4. Resolution of Appreciation; Reciprocal Invitation

On motion of Doctor Egan, variously seconded, the Council and Commission extended thanks to the Michigan Medical Society for the splendid hospitality.

On motion of Doctors Chojnacki–Carey, carried, the Council asked the staff and Executive Committee to see what arrangements might be made for a reciprocal invitation to Michigan to meet in Wisconsin.

5. Adjournment

The joint meeting adjourned at 11:15 a.m.

Respectfully submitted,

C. H. CROWNHART
Secretary

Approved:

E. J. NORDBY, M. D.
Chairman

MINUTES OF COUNCIL MEETING

MADISON, OCTOBER 19–20, 1968

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 1:55 p.m. on Saturday, October 19, 1968, at the State Medical Society.

Voting members present: Doctors Bayley, Schulz, Nordby, Carey, Sisk, Dettmann, Rohde, Ludwig, Manz, Houghton, Egan, Sullivan, Hollenbeck, President James, and Speaker Behnke; Doctors Stoops, Huth, Van Hecke, and Kief present Saturday only.

Officers and others present: President-elect Callan; Doctors Bell, Galasinski, and Picard; Doctors Hildebrand, Fox, and Collentine, Saturday only; Doctors Simenstad, Sunday only; Messrs. Crownhart, Thayer, Koenig, Reynolds, Brower, Maroney, Doran, Kluwin Murphy, Cameron, Gill; Mr. Tiffany, Saturday only; Mrs. Anderson, Misses Cordts and Pyre; Doctor Russell for special order on Sunday.

2. Approval of Minutes

On motion of Doctors Hollenbeck–Houghton, carried, minutes of the July 19 Council meeting and July 20 joint meeting with the Commission on Medical Care Plans were approved with incorporation of the revision submitted by Doctor Galasinski in reference to remarks made by him at the July 19 meeting.

3. 1968 Wisconsin Work Week of Health

Doctor James and Mr. Thayer supplemented orally the written report on attendance, comments, publicity, etc., which was distributed to those present. The report also included the recommendation that a program on youth and health be provided again in 1969, and on a regional basis so that a larger audience can be reached on subjects for which there is an apparent demand. It was proposed that there be one-day meetings in four or five locations, and with fewer topics treated in depth.

Doctor Kief expressed the hope that the Work Week of Health format of the past five years will not be discontinued if regional programs are held away from the Society headquarters.

On motion of Doctors Behnke–Hollenbeck, carried, the Council extended congratulations for the 1968 Work Week and approved plans for the future, combining programs at headquarters with regional extensions as deemed advisable.

4. Commission on Safe Transportation Recommendations

A. Slow-Moving Vehicle Emblem

On motion of Doctors Sullivan–Sisk, carried, the Council endorsed the following recommendations adopted by the American Medical Association in June, 1968:

(1) That the AMA officially endorse the SMV emblem and the objectives for which it stands, and commend the American Society of Agricultural Engineers, the Ohio State University and the National Safety Council for the devel-

opment of the idea and their assistance in its implementation.

(2) That the AMA, in cooperation with the state and county medical societies, promote the use of the SMV emblem on slow-moving vehicles and help to educate the public to recognize it as identifying these vehicles.

B. Conference on Highway Safety

On motion of Doctors Houghton–Schulz, carried, the Council approved co-sponsorship with the Wisconsin Council of Safety and program participation by members of the Commission on Safe Transportation in a conference on highway safety to be held January 27, 1969.

C. Appointments

On motion of Doctors Egan–Stoops, carried, the Council concurred in appointments by Chairman Nordby to two vacancies on this Commission: James Huffer, M.D., Madison, and J. D. Farrington, M.D., Minocqua.

5. Health Care Costs

There was considerable discussion of this general subject, with Doctors Callan and Collentine giving their impressions of the recent Regional Conference in Cleveland called by HEW Secretary Cohen. Doctor Kief spoke of the need for voluntary demonstrations on the control of health costs at the local level, and urged that action be taken on his proposal for a Comprehensive Health Expenditures Commission which the Council has referred to its Committee on Economic Medicine. The following actions were taken on the subject:

A. The Executive Committee reported its action to invite all Wisconsin individuals invited to the Cleveland conference to meet at the Society the morning of November 16 in an initial effort to relate the program content to the state scene.

B. On motion of Doctors Van Hecke–Hollenbeck, carried, the Council approved the recommendation of the Executive Committee that the June 1968 Wisconsin resolution to the AMA calling for a study of health care costs be reintroduced.

C. On motion of Doctors Kief–Egan, carried, the Committee on Economic Medicine was asked to review the subject after the November 16 meeting and report at the next Council meeting.

6. Report of Commission on Medical Care Plans

On motion of Doctors Ludwig–Houghton, carried, the Council rescinded its action earlier in the year approving a recommendation of the Commission that a formal protest be made to the State Department of Health and Social Services in reference to Title XIX reimbursement procedures for drugs dispensed by physicians, inasmuch as the regulations were revised in the interim to a satisfactory provision.

Mr. Koenig reported for information on current activities of interest to the Council, including:

A. Discussions with the Wisconsin Dental Service Corporation in reference to possible future relationships with WPS in the dental insurance field.

B. The position of WPS as carrier for Part B of Medicare in reference to intermediary letters of the Social Security Administration relating to the availability and use of Title XVIII information for complementary insurance purposes, which is one of endorsing the position taken by the National Association of Blue Shield Plans protesting them and requesting further review.

C. Actions at a special meeting of Plans in October which, among others, require all Plans to make available a paid-in-full program on a usual, customary and reasonable charge basis.

The Council recessed at 3:35 p.m. for the annual meeting of the board of trustees of the Charitable, Educational and Scientific Foundation, and reconvened at 9:00 a.m. on Sunday, October 20, 1968.

7. Report of Ad Hoc Committee on the Medical Practice Act

W. T. Russell, M.D., chairman, discussed proposed amendments to the Medical Practice Act. These had been circulated to the Council prior to the meeting, and constitute a partial report of the special committee. He said that if approved by the Council, the proposed amendments would be submitted to the Medical Examining Board, and with its concurrence legislation would be drafted.

On motion of Doctors Bayley–Sisk, carried, the proposed amendments were approved for such referral. Since they are proposals only at this time, they are not incorporated in these minutes.

8. Meetings of Neighboring State Societies

President James reported informally on his attendance at annual meetings in Illinois, Michigan, and Indiana.

9. Comprehensive Health Planning

The Executive Committee recommended that the Council state officially that it encourages individual physicians and county societies to become knowledgeable in this matter and to participate and provide leadership in the formation of local groups; further, that the Society office disseminate such information as is available in advance of area planning conferences; and further, that county societies be encouraged to devote an early meeting entirely to this subject.

Also reported was the plan to devote the afternoon of November 16 to a meeting for all interested phyisicans, with county societies being urged in particular to send representatives of local comprehensive health planning committees.

On motion of Doctors Ludwig–Sullivan, carried, the recommendation of the Executive Committee was adopted.

10. Title XIX—Medicaid

Mr. Doran reported that impending cuts in Medicaid appropriations had not been adopted before Congress adjourned, but stated his opinion that the principles of free choice and usual, customary and reasonable fees would be tested in the Wisconsin Legislature in the coming year.

On motion of Doctors Sullivan–Sisk, carried, the Council affirmed adherence to usual, customary and reasonable fees for statewide welfare cost consideration, and the principle of free choice of physician.

11. Health Education in Schools

Published reports by the State Department of Public Instruction indicate that health courses offered for credit in Wisconsin schools are increasing from year to year. Mr. Maroney indicated that the Division on School Health has worked to some de-

gree with the State Department in the area of health education, but suggested that the Council might request the Division to become more involved in curriculum planning and in other ways to advance the teaching of health.

On motion of Doctors Egan–Schulz, carried, the Council received the report and encouraged the Division on School Health to work in areas of health education activity.

12. Report of Planning Committee

A. Medical School Graduation Luncheons

After reviewing a report indicating the apparent success of the luncheons held last June for the medical school graduating classes of Marquette and the University of Wisconsin, the Planning Committee took action to recommend to the Council that the luncheons be continued for the year 1969.

The recommendation was approved on motion of Doctors Manz–Sullivan, carried.

B. Abortion

After considering the statement on abortion adopted by the American Medical Association, the work of the committee that recommended the AMA statement, and the present Wisconsin law, the committee agreed that the principal medical concern in adopting such a position should be preserving the life of the mother. It was recognized that many other sociological and legal factors necessarily enter into any discussion on abortion, but the committee felt that any official opinion from the State Medical Society should concern itself primarily with the medical issue involved.

The Planning Committee recommended to the Council that the Society take the position that it favors the present Wisconsin law which permits abortion in a medical situation which would endanger the life of the mother.

The recommended position was adopted on motion of Doctors Manz–Sullivan, carried.

C. Licensing of Psychologists

The committee reviewed the proposed 1969 legislation which would license psychologists and noted that the Division on Nervous and Mental Diseases recommended opposition to licensure, and that the Executive Committee of Public Policy recommended that the Society attempt to work out legislation with the psychologists that would be mutually agreeable.

After considering the positions of these committees, the Planning Committee recommended affirmation of action adopted by the Council and the House of Delegates in 1962 in a "Statement on Fields Ancillary to Medicine," but recommended that if psychologists are to seek licensure, they should be included in the basic science examination and be held to the same standards as those practicing medicine when a malpractice accusation arises. In addition, it was emphasized that psychologists should work under medical supervision, and that any licensure bill should have a provision establishing this procedure unless they agree to take the basic science examinations and be held to the same standards of practice as medicine.

In discussion, it was pointed out to the Council that the ad hoc committee on the Medical Practice Act is considering the problems of certification, registration and licensure of all the ancillary health fields.

On motion of Doctors Manz–Schulz, carried, the recommendation of the Planning Committee was approved.

D. Membership Status of Residents

Upon referral by the Council, the Planning Committee considered methods of amending the constitution and bylaws to give residents the right to vote, hold office and committee membership.

The committee recommended the following addition to the Society's constitution and bylaws with the note that it is intended that such change not make residents full-paid members in the sense that they are counted for determining the number of delegates from a particular county medical society in the State Society's House of Delegates:

> Add the following to Chapter XI, Sec. 3, paragraph five: "Such resident members shall have the right to vote and hold office."

On motion of Doctors Manz–Houghton, carried, the proposed amendment was approved and forwarded to the House of Delegates.

13. Further Report of Executive Committee

A. Recommendation of Division on Maternal and Child Welfare

The Executive Committee recommended Council approval of the proposal of this Division that the AMA be encouraged to hold an annual perinatal conference . . . approved on motion of Doctors Schulz–Bayley, carried.

B. Review of Committee Projects

In light of added responsibilities placed upon physicians and staff by such programs as comprehensive health planning, the Executive Committee will ask all committee chairmen to review and submit their pending and proposed projects with fiscal implications to determine if some priorities might be established. It may ask for a meeting with the chairmen later after the budgetary impact can be measured. Report accepted on motion of Doctors Egan–Bayley, carried.

C. Invitation to Section Officers

The committee reported that it proposes to invite officers of the scientific sections to meet with the Council at its late February or March meeting, as previously authorized.

D. Resolution J

Mr. Brower reported the recommendation of Doctors Bayley and Van Hecke, who were asked by the Executive Committee to consider possible courses of action in reference to this resolution, introduced by the Section on Pathology and adopted by the House of Delegates in May, 1968, in light of a motion subsequently adopted by the State Council on Health as follows:

> "The Council on Health recognizes the importance of the cooperation of organized medicine in the conduct of many Federal programs affecting the medical practitioner. It believes that since the Division of Health is an agent of the Social Security Agency that enforcement of the regulations in accordance with the interpretations and definitions of that Agency is mandatory and that any requests for changes in the regulations should be made by organized medicine rather than by the Council on Health."

On motion of Doctors Bayley–Sullivan, carried, the Council accepted the recommendation that a statement be developed outlining the background of health and welfare programs in Wisconsin up to the present day, and asking the Council on Health for reconsideration and the establishment of review mechanisms on implementing regulations; that such procedure and statement first be resubmitted to the specialty involved in this

instance for affirmation of the avenue of approach or suggestion of an alternative.

E. Communications Center

The Executive Committee recommended installation of the mechanical equipment required for providing recorded messages by telephone on health information subjects, the same system to be used for fast responses to news media on inquiries related to current events. Initial installation cost would approximate $1,000, and thereafter direct costs would be the monthly telephone toll charges.

On motion of Doctors Sullivan–Ludwig, carried, the recommendation was approved.

F. Council Award and Presidential Citation

President James advised that his nominations for these awards at the 1969 Annual Meeting will be circulated for mail ballot and require unanimous vote of the Council.

G. AMA Division of Public Affairs

The Executive Committee reported acceptance of the advice of the Secretary and of legal counsel in reference to this new AMA division, which will amalgamate certain field service activities formerly conducted by AMPAC staff, to the effect that the State Medical Society of Wisconsin notify the AMA that all contact on political matters must continue to be with the Professional Association for Civic Education.

On motion of Doctors Schulz–Ludwig, carried, the Council approved such notification.

14. North Central Conference

On motion of Doctors Ludwig–Schulz, carried, the Council authorized the AMA delegates as official representatives of the Society at the North Central Conference.

15. New Committee Appointments

On motion of Doctors Egan–Schulz, carried, the Council concurred with the appointments of Chairman Nordby to two new committees as follows:

Committee on Medicine and Religion

Annual appointments:
John O. Simenstad, M.D., Osceola, Chairman
R. W. Shropshire, M.D., Madison
F. J. Cerny, M.D., Fond du Lac
Maxwell Weingarten, M.D., Milwaukee
Joseph R. Matt, M.D., Oconomowoc

Commission on Wisconsin's Health and Natural Resources

Three years:
David L. Morris, M.D., West Salem, Chairman
S. J. Graiewski, M.D., Oshkosh
O. A. Sander, M.D., Milwaukee

Two years:
Maurice G. Rice, M.D., Stevens Point
John Noble, M.D., Black River Falls
John B. Davis, M.D., Madison

One year:
R. J. Sneed, M.D., Ashland
George W. Dean, M.D., Milwaukee
Louis W. Chosy, M.D., Madison

16. Wisconsin Society of Anesthesiologists

The Council discussed briefly a letter addressed to the chairman from the Wisconsin Society of Anesthesiologists requesting investigation of the practice of WPS paying anesthesia benefits involving the services of nurse anesthetists billed by physicians. The position of the Commission on Medical Care Plans was reported, that it does not believe it is the prerogative of WPS as an insurance device to question individual claim forms of physicians. It was pointed out also that with the growth of technicians, this communication represents only one facet of a broad subject, and a comparable situation exists as between psychiatrists and clinical psychologists, for example. The Secretary suggested that the entire matter be referred to the Planning Committee for study and consultation with those involved, with report back to the Council.

On motion of Doctor Sullivan, seconded and carried, the matter was so referred to the Planning Committee.

17. Election of Nonmedical Trustees of CES Foundation

These elections are by the Council. Seven nominations were made at the Foundation board meeting the prior day, and on motion of Doctors Houghton–Schulz, carried, the Council requested that all be invited to serve on the board of trustees of the Foundation.

18. Comments by the Secretary

Mr. Crownhart discussed generally the problems confronting management, particularly in providing space not only for office help, but for the large volume of records accumulating from the government programs which must be stored and yet available for referral.

Doctor Callan commented on the great impact on physicians of the paper work associated with the government programs resulting in a loss of productivity. He urged that steps be taken to facilitate the handling of small claims by the fiscal agents, or he feared that some physicians will no longer accept Medicaid cases.

On motion of Doctors Houghton–Hollenbeck, carried, this problem was referred to the Committee on Economic Medicine for consultation with the carrier and report back to the Council.

19. Adjournment

The meeting adjourned at 11:10 a.m.

Respectfully submitted,
C. H. CROWNHART
Secretary

Approved:
E. J. NORDBY, M.D.
Chairman
(Subject to formal approval by the Council.)

How to file claims for persons eligible for Railroad Medicare and the Wisconsin Medical Assistance Program (Medicaid)

When the patient is eligible for services under both programs, Railroad Medicare must determine its liability before the Wisconsin Medical Assistance Program can pay a claim. The key to filing these claims, therefore, lies in filing them with Railroad Medicare first. The carrier for the Railroad Medicare program is the Travelers Insurance Company.

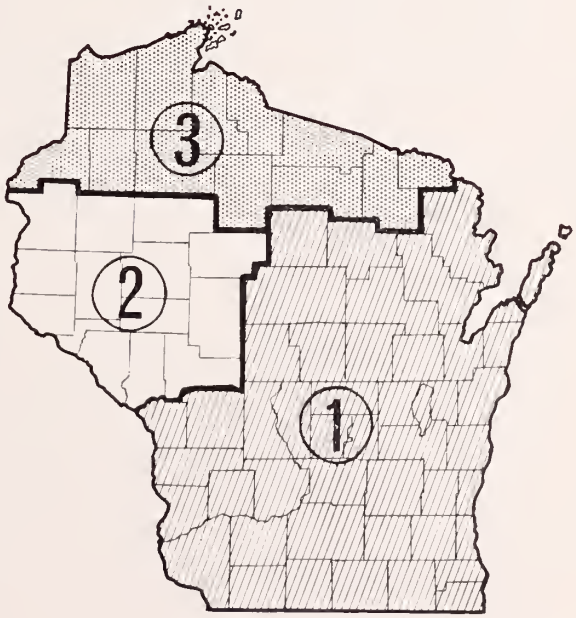
Unlike regular Medicare claims, which the provider files with the carrier in his state, he must file the Railroad Medicare claim with the office of the Travelers Insurance Company as determined by the county in which the patient is currently living. In Wisconsin the division appears on the following map:

Claims for persons living in the three areas may be filed at the following Travelers Insurance Company offices:

Area 1 811 East Wisconsin Avenue
Milwaukee, Wis. 53202

Area 2 310 Cedar Street
St. Paul, Minn. 55101

Area 3 5 North Third Avenue
West Duluth, Minn. 55802



ALSO SEE FOLLOWING PAGE FOR FURTHER DETAILS

Because Wisconsin Medical Assistance claims cannot be paid until Railroad Medicare has determined its liability, it is important that filing of the claim with the Wisconsin Medical Assistance Program be delayed until you receive the E.O.B. (Explanation of Benefits form) from the Travelers Insurance Company. Providers of service (outside Milwaukee County) can then forward the Wisconsin Medical Assistance claim to WPS with a copy of the E.O.B. attached. This will provide WPS with the information required, and the Wisconsin Medical Assistance claim can be promptly processed.

Wisconsin Physicians Service (WPS), the Blue Shield division of the State Medical Society of Wisconsin, is the contractor for the administration of the Wisconsin Medical Assistance Program (Medicaid) throughout Wisconsin except in Milwaukee County, which is served by Surgical Care—Blue Shield. The Department of Health and Social Services of the State of Wisconsin has responsibility for the overall administration of the Wisconsin Medical Assistance Program.

If you should have any questions regarding the completion or payment of claim report forms, please direct them as follows:

Attention: Title XIX
Wisconsin Physicians Service
Box 1109
Madison, Wisconsin 53701

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 67, No. 1 JANUARY 1968

SPECIAL FEATURES

Malpractice—The Layman's Common Medical Knowledge and Experience and Res Ipsa Loquitur ---- 4
Immunization Information for International Travel, 1967–68 Edition ---- 8
The Professional Corporation in 1967 ---- 11
Joint Commission Standards Governing Hospital Privileges for Podiatrists ---- 14
The Right to Use the Title "Doctor" in Wisconsin ---- 16
Post Mortem Examination ---- 17
Medical Evaluation of Driver Impairment ---- 18
Physicians Exempt from Jury Duty ---- 19
Can You Practice Without a License? ---- 19
What Every Doctor Should Know About Workmen's Compensation ---- 20
The Abused Child Law ---- 27
Blood Grouping Test for Identification ---- 28
Consents for Treatment of a Minor ---- 28
Rehabilitation of the Epileptic in Wisconsin, by Jean P. Davis, M.D., Milwaukee; and Adrian E. Towne, Madison ---- 29
Drivers' Licenses for Epileptics ---- 30
When a Lawyer Asks You for a Report, by Winfield S. Miller, LL.B., Oradell, N. J. ---- 31
Are You Risking an Abandonment Charge?, by Neil L. Chayet, Esq., Boston, Mass. ---- 33
Sale of Contraceptives and Abortifacients ---- 35
Law Requires Silver Nitrate to Prevent Infant Blindness ---- 35
The Expert Witness, by Benjamin J. Cantor, B.E.E., LL.B. ---- 36
Medical Staffing of Emergency Rooms; Legal and Ethical Considerations, by Wayne E. Stichter, Juris Doctor, Toledo, O. ---- 38
Recent Changes in Self-Employed Retirement Plans ---- 42
Charitable, Educational and Scientific Foundation ---- 42
Physician and Hospital Records Retention and Inspection ---- 43
An Interpretation of Chapter 301; Laws of 1959 ---- 45
Joint Commission Standards for Dentistry in Hospitals ---- 48
The Physician and Legal Medicine ---- 49
Problems of a Physician's Widow ---- 50
Legal Responsibilities of the Physician–Patient–Hospital Relationship ---- 51
Malpractice Defined ---- 53
Narcotics ---- 53
Physicians' Guidelines for Delegation of Duties and Functions to Nurses ---- 54
Abortion and the Wisconsin Law ---- 55
The Wisconsin Legislature; Directory of Members ---- 56
Tax Deductibility of Health and Accident Insurance ---- 56
Refer Child Placement Cases to These Agencies ---- 59
Poison Information Centers ---- 59
Your Deadlines and Other "Musts" ---- 60
Statute Authorizes Gifts of Human Bodies or Parts ---- 61
Charter Law of Medical Societies in Wisconsin ---- 62
Constitution and Bylaws of the State Medical Society of Wisconsin ---- 63
Control of LSD ---- 71
Principles of Medical Ethics of the American Medical Association ---- 72
Schedule of Programs of the "March of Medicine" ---- 73
SMS Services to Members ---- 74
List of Members, State Medical Society of Wisconsin ---- 75
Map Indicating Location of Councilor Districts ---- 88
SMS Officers and Councilors 1967–1968 ---- 89
SMS Standing Committees 1967–1968 ---- 90
Component Council Committees 1967–1968 92
SMS Council Committees 1967–1968 ---- 93
Officers of Scientific Sections of SMS ---- 94
Presidents and Secretaries, Wisconsin Specialty Societies ---- 95
List of Officers and Directors, Woman's Auxiliary to SMS ---- 95
Past Presidents of SMS ---- 96
Recipients of the Council Award ---- 97
Recipients of the Presidential Citation ---- 97

continued on next page

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Journal
Established 1903

Annual Subscription ----$10.00
Single Copy ---- 1.50
Previous Years' ---- 3.00
January Blue Book ---- 5.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.

CONTENTS *continued*

Career Guide: Find Your Future in the Health Field 97
List of Officers and Board of Trustees of the Charitable, Educational and Scientific Foundation 98
Organizational Chart: Department of Health and Social Services 99
List of Members of the Board and Executive Staff: Department of Health and Social Services 99
List of Officers, Bureaus, and District Offices: Division of Health 100
List of Personnel and Districts: Division of Vocational Rehabilitation 102
List of Officers of State Boards and Commissions 102
Placement Service Aids Doctors and Communities 103
The Spectrum of Patient Care Viewed by a Nurse, by Eleanor C. Lambertsen, Ed.D., R.N., New York 107
Services Offered by TB Outpatient Clinics in Wisconsin 109
Minutes of Council Meeting, Madison, November 4, 1967 110
Wisconsin's Health: Nursing Homes Complete First Year Under Medicare; Nursing Homes Directory Lists 34,267 Beds, by E. H. Jorris, M.D., State Health Officer 112
Tentative Scientific Program, SMS 1968 Annual Meeting 45*
Tentative Schedule—Orthopedic Field Clinics 49*
Annual Photography Contest; 1968 Annual Meeting 51*
Medical Art Salon; 1968 Annual Meeting 53*
Services to Physicians and the Public 56*
List of 1967 Advertisers 65*
Principles of Advertising 66*
Let These Guides Help You 70*
Map Indicating Location of State Medical Society Offices 71*

EDITORIALS

President's Page: Our Aims Are Our Duties, by Harold J. Kief, M.D., Fond du Lac 104
The Peripatetic Practitioner 106

REGULAR FEATURES

Publication Information 6*
List of State and County Medical Society Officers 2
Medical Meetings 41*
Society Records 55*
Recent Wisconsin Licentiates 61*
Physicians Exchange 67*
Index to Advertisers 70*

* Advertising section.

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances, manuscripts are published about six months following acceptance, and in the order in which they are received.

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RESPONSIBILITY. Publication of the WISCONSIN MEDICAL JOURNAL is under the direction of the Council of the State Medical Society of Wisconsin, with coordination through the Commission on Scientific Medicine. The Medical Editor and Editorial Board are responsible for the Scientific Content. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production, business operation, and all other contents of the JOURNAL, as well as final responsibility of the entire publication.

Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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CIRCULATION. Members of the State Medical Society of Wisconsin receive the WISCONSIN MEDICAL JOURNAL as part of their membership dues. Others who have related activities in medicine may receive the JOURNAL complimentary or may subscribe at the following rates: $10.00, one year; $1.50, single copy; $3.00 previous years; $5.00 January Blue Book. The JOURNAL reserves the right to control its circulation.

SAVE YOUR "BLUE BOOK" ISSUE FOR FUTURE REFERENCE

This January "Blue Book" issue of the *Wisconsin Medical Journal* contains a variety of articles relating to medicolegal matters of direct concern to the physician in his relationship to governmental agencies. An annual presentation since 1924, the edition is unique among medical journals of the United States. Each one has been an outstanding legal service to members of the Society. A permanent file of these issues for future reference is recommended.

MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 WISCONSIN

Feb. 12–13: Mt. Telemark Ski Outing and Scientific Meeting, Wisconsin Academy of General Practice, Indianhead Chapter host, Cable.

Feb. 12–23: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Feb. 13–15: Annual meeting, Wisconsin Academy of General Practice, Mt. Telemark, Cable.

Feb. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 4: Postgraduate course, "Hypoglycemias in Infants and Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11: Postgraduate course, "Etiology and Management of Nephrosis in Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11–22: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Mar. 18: Postgraduate course, "Prevention of Mental Retardation," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 23: Town and Gown Symposium, State Medical Society of Wisconsin, Madison.

Mar. 25: Postgraduate course, "Emotional Crises Among Adolescents," sponsored by Marquette University, Milwaukee.

Mar. 27–28: Third Annual Sports Medicine Conference, University of Wisconsin Medical Center and Extension, Madison.

Apr. 4–5: Wisconsin Anti-Tuberculosis annual meeting, Milwaukee.

Apr. 4–6: Symposium on "Fetal Medicine," Department of Pediatrics, University of Wisconsin Medical Center, Madison.

Apr. 18–19: Conference for Directors of Nursing in Small Hospitals, University Extension, Marshfield.

Apr. 22–May 3: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

May 9–10: Conference for Directors of Nursing in Small Hospitals, University Extension, Madison.

May 14–16: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June 7–9: Meeting of Wisconsin Society of Pathologists, "Pitfalls in Dermapathological Diagnosis" by Dr. Arthur C. Allen. (Location undetermined)

Sept. 14–15 (tentative): Fall meeting, Wisconsin Otolaryngological Society.

Sept. 21: Fall meeting, Wisconsin Surgical Society, St. Mary's Hospital, Madison.

Sept. 12–14: Fall meeting, Wisconsin Society of Internal Medicine, Oshkosh, at The Pioneer.

Sept. 14–15: Fall meeting, Wisconsin Society of Anesthesiologists, Lake Geneva, at the Playboy Club.

Sept. 20–22: Fall meeting, Wisconsin Radiological Society, Lake Geneva, at the Playboy Club.

Sept. 25–26: Annual meeting, Wisconsin Academy of General Practice, Pfister Hotel, Milwaukee.

Oct. 8–11: Meeting of the Wisconsin Nurses Association, Sheraton–Schroeder Hotel, Milwaukee.

Oct. 9–10: Meeting of Wisconsin Division, American Cancer Society, Oshkosh.

Nov. 16: Annual meeting, Wisconsin Society of Pathologists. (Location undetermined)

1968 NEIGHBORING STATES

Mar. 7–8: "The Doctor and His Hospital," Workshop, The Institute of Medicine of Chicago, Pick–Congress Hotel, Chicago, Ill.

Mar. 14–16: "The Clinical Selection of Patients for Cardiac Surgery, American College of Physicians, Mayo Graduate School of Medicine (University of Minnesota) and Mayo Clinic, Rochester, Minn.

Mar. 25–Apr. 6: Postgraduate course in Laryngology and Bronchoesophagology, Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, Ill.

Apr. 22–26: "Clinical Endocrinology—Recent Advances in Diagnosis and Treatment," American College of Physicians, Mayo Graduate School of Medicine (University of Minnesota) and Mayo Clinic, Rochester, Minn.

May 2–3: Scientific sessions, Illinois Heart Association, Springfield, Ill.

May 2–4: "Prevention in Cardiology," Minnesota Heart Association and the Mayo Clinic, Rochester, Minn.

May 10–11: "Electrophysiology and Electrocardiography," Michigan Heart Association, Detroit, Mich.

June 10–14: "Internal Medicine," American College of Physicians, University of Iowa School of Medicine, Iowa City, Ia.

Sept. 26–29: "The Metabolic Basis of Heart Disease," American College of Physicians, Wayne State University School of Medicine, Detroit, Mich.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

1968 OTHERS

Feb. 19–21: First of three 1968 sectional meetings in Dallas, Tex., of the American College of Surgeons.

Feb. 19–23: "Intensive Care Units," American College of Physicians, University of Cincinnati College of Medicine, Cincinnati, Ohio.

Mar. 4–7: New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.

Apr. 21–27: Interamerican Congress of Cardiology, Lima, Peru.

Apr. 22–25: American Industrial Health Conference, Hilton Hotel, San Francisco, Calif.

May 4–9: Annual teaching seminar, International Academy of Proctology, Montreux–Palace Hotel, Montreux, Switzerland.

May 13–17: Annual meeting, Ohio State Medical Association, Cincinnati, the Netherland Hilton Hotel.

June 19: Joint Session of the American College of Cardiology with the Section of Internal Medicine of the American Medical Association and the American Heart Association, AMA Annual Meeting, San Francisco, Calif.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo.

Sept. 28–Oct. 3: Western Hemisphere Congress, International College of Surgeons, Honolulu, Hawaii.

Oct. 6–11: XVI Biennial International Congress, International College of Surgeons, Tokyo, Japan.

Oct. 16–26: Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, International College of Surgeons.

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MEDICAL MEETINGS *continued*

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

Oct. 26–Nov. 11: Around-the-World Postgraduate Clinics, International College of Surgeons, India, Egypt, Holy Land, Israel, and Greece.

Nov. 19–20: 22nd Annual Meeting, American Heart Association Council on Arteriosclerosis, Bal Harbour, Fla.

Nov. 21–24: 41st Scientific Sessions, American Heart Association, Bal Harbour, Fla.

Nov. 25–26: Annual Assembly Meeting, American Heart Association, Bal Harbour, Fla.

1969 OTHERS

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

1968 AMA

Mar. 29–30: National Conference on Rural Health, Olympic Hotel, Seattle, Wash.

June 16–20: 117th Annual Convention, San Francisco, Calif.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF DECEMBER 1967

2 Fibrinogen and Blood Study Subcommittee, SMS Maternal Mortality Study Committee
2 SMS Maternal Mortality Study Committee
4 Madison Academy of Internal Medicine
5 Board of Trustees, Dane County Medical Society
5 Surgical Staff, Madison General Hospital
5 Madison Urological Society
5 Madison Anesthesiology Society
6 UW "In-depth" Scientific Program
7 SMS Division on School Health
8 Fourth Year UW Medical Students, Community and Occupational Health Program and SMS Orientation
9 State University Student Health Services Association
12 Cardiology Study Committee, Wisconsin Regional Medical Program
12 Board of Directors, Wisconsin Association of Professions
12 Board of Directors, Nelson Muffler Corp.
13 Board of Trustees, SMS Realty Corp.
13 Planning Committee, Wisconsin Regional Medical Program
14 Wisconsin Association, Student American Medical Association
15 SMS Commission on Scientific Medicine
15 SMS Ad Hoc Committee on The Medical Practice Act
21 Executive Committee, SMS Commission on Medical Care Plans
21 Cardiology Study Committee, Wisconsin Regional Medical Program

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics, with the location in parentheses.

Sports Medicine Conference, Madison

The University of Wisconsin Medical Center and University Extension are presenting the Third Annual Sports Medicine Conference March 27 and 28 on the University of Wisconsin Campus. The conference will be built on the requests for specific topics made by those who attended in 1967. The first morning session will be devoted to the techniques of taping and bandaging both for prevention and treatment of sports injuries. There will be lectures on "Injuries to the Male Genitalia," "Knee Injuries in Sports," "Charlie Horse and Hamstring Injuries," and other related subjects. There will be a tour of the new Men's Gymnasium, showing all the new facilities.

The conference is open to all physicians, coaches, trainers, and any other interested individuals. For further information contact: Thomas C. Meyer, M.D., Coordinator, Postgraduate Medicine, Room 302, 333 N. Randall Ave., Madison, Wis. 53706.

Symposium on Fetal Medicine, Madison

The Department of Pediatrics, University of Wisconsin Medical Center, will present a symposium on "Fetal Medicine" April 4–6 at the Wisconsin Center on the University of Wisconsin Campus in Madison.

The conference co-chairmen are Drs. Stanley Grave and George Kerr. The program will cover structural, biochemical, endocrine and genetic aspects of fetal growth and development, fetal diagnosis, fetal and maternal relationship and extrauterine adaption.

Guest speakers include Drs. Frederick Battaglia, Edward Hon, Robert Greenberg, Thomas K. Oliver, and Alex Robertson.

For further information contact Thomas C. Meyer, M.D., Associate Dean, Department of Postgraduate Medical Education, Room 302, 333 N. Randall Ave., Madison, Wis. 53706.

Doctor–Hospital Workshop in Chicago

Eight of the nation's foremost health authorities have been named as panel moderators for "The Doctor and His Hospital" Workshop to be held Mar. 7–8 at the Pick-Congress Hotel, Chicago.

The two-day meeting, sponsored by the Institute of Medicine of Chicago, is expected to be attended by over 1,000 physicians, administrators, trustees, and others concerned with the increasing problems confronting hospitals and the patients they serve.

Moderators are Frederick N. Elliott, M.D., Director, Bureau of Professional Services, American Hospital Association; James E. Eckenhoff, M.D., Professor and Chairman, Department of Anesthesia, Northwestern University School of Medicine; William W. Engstrom, M.D., Professor and Chairman, Department of Medicine, Marquette School of Medicine;

John M. Stagl, Director, Passavant Memorial Hospital, Chicago; Donald J. Caseley, M.D., Medical Director, Research and Educational Hospitals, and Associate Dean, College of Medicine, University of Illinois at the Medical Center, Chicago; Hiram Sibley, Executive Director, Hospital Planning Council of Metropolitan Chicago; LeRoy P. Levitt, M.D., Dean, The Chicago Medical School; and William L. Alexander, President, Board of Trustees, Chicago Wesley Memorial Hospital.

Tennis Tournament in Florida

The first organized tennis event of the American Medical Tennis Association (AMTA) is scheduled for Feb. 14–17 at the Holiday Parks courts in Fort Lauderdale, Fla. AMTA correspondence addressed to AMTA, c/o Rx Golf and Travel Magazine, Box 25125, Oklahoma City, Okla. 73125.

Program on Anticoagulants, Madison

March 21 is the date set for the program on Anticoagulants sponsored by the University of Wisconsin Medical Center in cooperation with the State Medical Society. The morning program will be devoted to patient discussions at the University Hospitals. Lunch and an afternoon program will be held at the State Medical Society headquarters. Four hours of AAGP credit will be allowed.

Faculty includes Park W. Willis, M.D. (Ann Arbor); Ovid O. Meyer, M.D.; Donald R. Korst, M.D.; Dallas V. Clatanoff, M.D.; John H. Morledge, M.D.; Alfred L. Kennan, M.D.; Kenneth M. Klatt,

TOWN AND GOWN SYMPOSIUM

Sponsored by the State Medical Society of Wisconsin

at Society Heaquarters in Madison
330 East Lakeside Street

Saturday, March 23, 10 a.m.

Theme: *Delivery of Medical Services and the Teaching of Medicine*

Participants

JAMES L. DENNIS, M.D.
Vice-president and Dean, The University of Oklahoma Medical Center, Oklahoma City

Title: *Does Medical Education Have a Role in the Delivery of Health Services?*

JOHN H. MOXLEY, III, M.D.
Assistant to the Dean, Harvard Medical School, Boston, Mass.

Title: *Pending*

THIRD SPEAKER PENDING

The afternoon session will be broken into four or five small discussion groups. The groups will join again about 4 p.m. for a windup and conclusion of the program.

A Postgraduate Education Program under the direction of the State Medical Society's Commission on Hospital Relations and Medical Education with support of the Society's Charitable, Educational and Scientific Foundation.

M.D. Topics concern Patient Presentations, Basic Mechanisms and Laboratory Control, Use in Cerebrovascular Disease and Chronic Cardiac Disease, Complications and Their Management, Clinical Uses in Surgical, Obstetric and Orthopedic Problems.

Registration fee: $5.00. Contact the State Medical Society, Box 1109, Madison, Wis. 53701.

Hypertension Program, Madison

The University of Wisconsin Medical Center in cooperation with the State Medical Society is presenting a program on Hypertension Feb. 21 in Madison. The program will start at University Hospitals at 10 a.m. for patient discussions. A luncheon will be served at the State Medical Society headquarters at 12:30 p.m. followed by an afternoon program on Diagnosis of Hypertension, Validity of Clinical Tests in Hypertension, Renal Hypertension, and Physiological Effects of Drugs in Hypertension.

Faculty includes: Harriet P. Dustan, M.D. (Cleveland); Charles W. Crumpton, M.D.; William C. Boake, M.D.; Richard E. Rieselbach, M.D.; Theodore Goodfriend, M.D.; and Neville Bittar, M.D.

Registration fee: $5.00. Contact State Medical Society, Box 1109, Madison, Wis. 53701. Four hours of AAGP credit will be allowed.

Surgery of the Hand, Colorado

The Office of Postgraduate Medical Education, University of Colorado School of Medicine, Denver, will present a program on Surgery of the Hand, Feb. 20–23, at Humphreys Postgraduate Center. Tuition and registration fee: $80, payable to the U. of Colo. School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

CONTINUING EDUCATION PROGRAM

UNIVERSITY OF WISCONSIN

The following continuing education programs are provided by the University of Wisconsin, through University Extension and the Medical Center. Those marked (*) are presented in cooperation with the Wisconsin Regional Medical Program, Inc.

On-Campus Courses

Three courses are scheduled this Spring. Additional courses will be announced as dates are set.

Feb. 7– 8 A Symposium on Modern Separation Methods of Macromolecules and Particles

Mar. 27–28 Third Annual Postgraduate Teaching Day in Sports Medicine

Apr. 4– 6 A Symposium on Fetal Medicine

Telephone/Radio Conferences

This year 68 hospitals are taking part in conferences for physicians and allied health personnel. Hospital enrollment for the next academic year will begin this Spring, with programming planned for the following personnel:

Physicians
- General Medical Seminars
- 4–6 Specialized Medical Courses

Allied Health Personnel
- Hospital Administrators
- Medical Technologists
- Radiological Technologists
- Nurse Anesthetists
- Medical Librarians

Telephone Dial Access Library*

Announcement of 175 recordings available by telephone is being made in January. Additional recordings will be announced on hospital bulletin boards as they become available.

Single-Concept Films*

A series of six films of 6–10 minutes duration, shown on an automatic projector in your hospital, is currently available. Fifteen additional films will be produced this year under the auspices of the Wisconsin Regional Medical Program, Inc.

Physician-In-Residence

One to two-week courses of individual study are available to physicians who wish to return to an academic setting for study in depth in a specific area. A course is presently available in Pediatrics and others will be arranged on individual request.

For further information on any of the programs, write: Thomas C. Meyer, M.D., Associate Dean for Postgraduate Education, Room 302, 333 North Randall Ave., Madison 53706. For courses associated with the Wisconsin Regional Medical Program, write: Roy T. Ragatz, Room 305, 333 North Randall Ave., Madison 53706.

TENTATIVE SCIENTIFIC PROGRAM

STATE MEDICAL SOCIETY OF WISCONSIN

1968 Annual Meeting • May 14–16

Milwaukee Auditorium and Hotel Schroeder

TUESDAY, MAY 14: MORNING SESSION

Osteoporosis

1. THE EFFECT OF AGE AND POSTMENOPAUSAL OSTEOPOROSIS ON THE INTESTINAL ABSORPTION OF CALCIUM
   Louis V. Avioli, MD, St. Louis, Mo.
2. FACTORS INVOLVED IN THE DEVELOPMENT OF OSTEOPOROSIS
   Robert P. Heaney, MD, Omaha, Neb.
3. PANEL DISCUSSION
   Doctors Avioli and Heaney.

TUESDAY, MAY 14: NOON LUNCHEONS

1. THE DIFFERENTIAL DIAGNOSIS OF HYPERCALCEMIA
   Louis V. Avioli, MD, St. Louis, Mo.
2. DIAGNOSIS AND TREATMENT OF METABOLIC BONE DISEASE
   Robert P. Heaney, MD, Omaha, Neb.
3. PHILOSOPHY OF RESPIRATORY CARE
   Thomas Lee Petty, MD, Denver, Colo.
4. TITLE PENDING
   Benjamin Burrows, MD, Chicago, Ill.
5. SELECTIVE ANGIOGRAPHY IN THE HEAD AND NECK
   William N. Hanafee, MD, Los Angeles, Calif.
6. ASEPTIC NECROSIS OF BONE
   William Martel, MD, Ann Arbor, Mich.
7. CHROMOSOMAL ASPECTS OF PREGNANCY WASTAGE
   David Yi-Yung Hsia, MD, Chicago, Ill.
8. URETHRAL SUSPENSION
   Richard F. Mattingly, MD, Milwaukee
9. CLOMID—ONE YEAR LATER
   Gloria E. Sarto, MD, Madison

TUESDAY, MAY 14: AFTERNOON SESSION

Medicine

Moderator: EDWARD K. RYDER, JR., MD, Madison

Three programs running concurrently: Medicine, Obstetrics–Gynecology, and Radiology

1. THE NATURAL HISTORY AND PROGNOSIS OF OBSTRUCTIVE EMPHYSEMA
   Benjamin Burrows, MD, Chicago, Ill.
2. PULMONARY REHABILITATION
   Thomas Lee Petty, MD, Denver, Colo.
3. PANEL DISCUSSION; QUESTIONS AND ANSWERS
   Doctors Burrows, Petty, Helen A. Dickie and John Rankin, Madison

Obstetrics & Gynecology

Moderator: Joseph C. Fralich, MD, Racine

1. GAMMA GLOBULIN IN THE PREVENTION OF RH. ISO-IMMUNIZATION
   Serafeim P. Masouredia, MD, Milwaukee
2. GENETIC FACTORS IN PREGNANCY WASTAGE
   David Yi-Yung Hsia, MD, Chicago, Ill.
3. OUR RESPONSIBILITY IN THE DEFINITION OF PATTERNS IN MATERNAL AND NEWBORN CARE
   Ben M. Peckham, MD, Madison
4. PANEL DISCUSSION
   Doctors Masouredia, Hsia, and Peckham

Radiology

Moderator: ANDREW B. CRUMMY, JR., MD, Madison

1. SELECTIVE ANGIOGRAPHY IN THE HEAD AND NECK
   William N. Hanafee, MD, Los Angeles, Calif.
2. THE SPONDYLITIS OF RHEUMATOID ARTHRITIS
   William Martel, MD, Ann Arbor, Mich.
3. PANEL DISCUSSION
   Doctors Hanafee and Martel

TUESDAY, MAY 14: EVENING EVENTS

1. RADIOLOGY DINNER
   Speaker: William Martel, MD, Ann Arbor, Mich.
   TOPIC: PRACTICAL POINTS IN THE DIAGNOSIS OF JOINT DISEASES
2. UNIVERSITY OF WISCONSIN MEDICAL ALUMNI ASSOCIATION DINNER
3. MARQUETTE MEDICAL ALUMNI ASSOCIATION DINNER

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Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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WED., MAY 15: MORNING SESSION

General

1. **USE OF COMPUTERS IN MEDICINE**
   Moderator: C. DANIEL GEISLER, SCD, Madison
   Participants: G. Phillip Hicks, PhD, Madison
   Vincent C. Rideout, MS, Madison
   Warner V. Slack, MD, Madison
2. **PROMISING NEW DEVICES FOR USE IN MEDICINE**
   Moderator: JOHN G. WEBSTER, PhD, Madison
   Participants: Edwin N. Lightfoot, PhD, Madison
   John W. Mitchell, PhD, Madison
   Stuart J. Updike, MD, Madison

WED., MAY 15: NOON LUNCHEONS

Eight programs running concurrently

1. **ALLERGIC DERMATOLOGIC MANIFESTATIONS OF ARTHROPOD EXPOSURE**
   Frank Perlman, MD, Portland, Ore.
2. **TREATMENT OF COMMON SKIN DISEASES**
   Arthur C. Curtis, MD, Ann Arbor, Mich.
3. **TITLE PENDING**
   J. Preston Robb, MD, Montreal, Canada
4. **IMMUNIZATIONS: PAST, PRESENT AND FUTURE**
   Vincent A. Fulginiti, MD, Denver, Colo.
5. **VASCULAR PROBLEMS ASSOCIATED WITH PREGNANCY**
   Richard D. Sautter, MD, Marshfield
6. **TITLE PENDING**
   William S. Middleton, MD, Madison
7. **BIOMEDICAL ENGINEERING RESEARCH**
   C. Daniel Geisler, ScD, Madison
8. **BIOMEDICAL INSTRUMENTATION**
   John G. Webster, PhD, Madison

WED., MAY 15: AFTERNOON SESSION

Four programs running concurrently: Allergy, Dermatology, Neurology, Pediatrics

Allergy

Moderator: DAVID M. GLASSNER, MD, Milwaukee

1. **EFFECTS OF NEBULIZED MEDICATION IN TREATMENT OF ASTHMA AND CHRONIC BRONCHOPULMONARY DISEASES**
   Frank Perlman, MD, Portland, Ore.

ABBREVIATED TIMETABLE

(Subject to Change)

Annual Meeting—State Medical Society

MAY 11–16, 1968—MILWAUKEE

pm	**SATURDAY, MAY 11**
5:30	Executive Committee—Council
pm	**SUNDAY, MAY 12**
12:00	Council Luncheon
2:00	Council Meeting
6:00	50-Year Club Dinner
pm	**MONDAY, MAY 13**
1:00	Congress of Delegates—Wisconsin Academy of General Practice
7:00	First Session—House of Delegates
am	**TUESDAY, MAY 14**
7:30	Breakfast—Professional Association for Civic Education (PACE)
8:30	Registration and opening of exhibits
9:00	Reference Committees
9:30	Scientific Program: "Osteoporosis"
pm	
12:00	Clinic Managers' Luncheon
12:30	Scientific Luncheons (9)
2:00	Scientific Programs in Medicine, Obstetrics–Gynecology, and Radiology
6:00	Buffet Supper—House of Delegates
6:00	Alumni Dinners—University of Wisconsin and Marquette
6:00	Radiology Dinner
7:30	Second Session—House of Delegates
am	**WEDNESDAY, MAY 15**
9:00	Third Session—House of Delegates
9:30	Scientific Programs in "Use of Computers in Medicine"
11:00	Council Meeting
pm	
12:30	Council Luncheon
12:30	Scientific Luncheons (8)
2:00	Scientific Programs in Dermatology, Neurology, and Pediatrics
6:00	President's Reception
7:00	Annual Dinner
am	**THURSDAY, MAY 16**
8:30	Clinic—Wisconsin Surgical Society at Wood VA Center
9:30	Scientific Programs in Ear–Nose–Throat, Ophthalmology, Resident–Intern Papers
pm	
12:30	Scientific Luncheons (8)
2:00	Scientific Programs in Anesthesia, Ophthalmology, and Surgery
2:00	SMS Section on Ear, Nose and Throat Business Meeting and Wisconsin Otolaryngology Society
7:00	Wisconsin Surgical Society Dinner

2. **CASE PRESENTATIONS: DIRE EFFECTS OF ABUSIVE SELF-ADMINISTERED NEBULIZED MEDICATION**
   David M. Glassner, MD, Milwaukee

3. **ROUNDTABLE DISCUSSION: THE USE AND ABUSE OF NEBULIZED MEDICATION**
   Frank Perlman, MD, Portland, Ore.
   Richard P. Jahn, MD, Milwaukee
   David M. Glassner, MD, Milwaukee

4. **RECENT ASPECTS OF PIGEON BREEDER'S DISEASE**
   Abe Sosman, MD, Milwaukee

Dermatology

Moderator: JAMES W. BRINGE, MD, Sheboygan

1. **TITLE PENDING**
   Arthur C. Curtis, MD, Ann Arbor, Mich.

2. **SKIN DISEASES AGGRAVATED BY SUNLIGHT**
   Derek J. Cripps, MD, Madison

3. **PANEL DISCUSSION**
   Arthur C. Curtis, MD, Ann Arbor, Mich.
   Derek J. Cripps, MD, Madison

Neurology

Moderator: FRANCIS M. FORSTER, MD, Madison

1. **CLINICAL DIAGNOSIS OF EPILEPSY**
   J. Preston Robb, MD, CM, Montreal, Canada

2. **ROLE OF ELECTROENCEPHALOGRAPHY IN THE DIAGNOSIS OF EPILEPSY**
   Francis M. Kruse, MD, Marshfield

3. **NEUROPSYCHOLOGICAL EVALUATION OF THE EPILEPTIC PATIENT**
   Charles G. Matthews, MD, Madison
   Hallgrim Klove, PhD, Madison

4. **MEDICAL MANAGEMENT OF EPILEPSY**
   Philip T. White, MD, Milwaukee

5. **SURGICAL MANAGEMENT OF THE EPILEPTIC**
   Flavio Puletti, MD, Madison

6. **CONDITIONING IN CERTAIN CASES OF EPILEPSY**
   Francis M. Forster, MD, Madison

7. **THE PHYSICIANS' ROLE IN HANDLING THE SOCIAL IMPLICATIONS OF EPILEPSY**
   Jean P. Davis, MD, Milwaukee

Pediatrics

Moderator: WILLIAM H. BARTLETT, MD, Madison

1. **THE INVESTIGATION AND TREATMENT OF GROWTH DISORDERS IN CHILDREN**
   George R. Kerr, MD, Madison

2. **QUESTION AND ANSWER PERIOD**

3. **PEPTIC ULCER IN CHILDREN, A FAMILIAL DISEASE**
   Frederic M. Blodgett, MD, Milwaukee

4. **QUESTION AND ANSWER PERIOD**

5. **A NEW LOOK AT IMMUNOLOGIC DEFICIENCY DISEASES**
   Vincent A. Fulginiti, MD, Denver, Colo.

6. **PANEL DISCUSSION**

THURSDAY, MAY 16: MORNING SESSION

General

Three programs running concurrently

1. **RESIDENT–INTERN PAPERS**
   Chairman: THOMAS V. GEPPERT, MD, Madison

2. **SECTION ON OPHTHALMOLOGY: CLINIC ON APPLANATION TONOMETRY**
   Chairman: JAMES V. BOLGER, MD, Milwaukee
   Luncheon and business meeting at noon

3. **WISCONSIN SURGICAL SOCIETY**
   Chairman: BEN R. LAWTON, MD, Marshfield

Ear–Nose–Throat

Moderator: JOHN K. SCOTT, MD, Madison

1. **AN OTOLARYNGOLOGIST'S APPROACH TO FACIAL FRACTURES**
   Willis G. McMillan, MD, Madison

2. **A SURGICAL APPROACH TO DEAFNESS**
   Michael Paparella, MD, Minneapolis, Minn.

3. **A GROUP APPROACH TO HEARING AND SPEECH PROBLEMS IN CHILDREN**
   Michael Paparella, MD, Minneapolis, Minn.
   Stanley Ewanowski, PhD, Madison
   Charles Tait, PhD, Madison

THURSDAY, MAY 16: NOON LUNCHEONS

Six programs running concurrently

1. **TITLE PENDING (Surgical)**
   John S. Najarian, MD, Minneapolis, Minn.

2. **THE PACEMAKER PATIENT: WILL THE CAUTERY TURN HIM OFF?**
   John M. R. Bruner, MD, Groton, Mass.

3. **THE OTOLOGIST'S APPROACH TO THE SUSPECTED DEAF PRE-SCHOOL CHILD**
   Michael Paparella, MD, Minneapolis, Minn.

4. **ENGINEERING IN MEDICINE AND BIOLOGY**
Anthony Sances, PhD, Milwaukee

5. **NEWER DRUGS AND THEIR USES**
Ovid O. Meyer, MD, Madison

6. **TITLE PENDING (Section on Ophthalmology)**
J. Lawton Smith, MD, Coral Gables, Fla.

7. **HEADACHES**
J. D. Kabler, MD, Madison

8. **NEW DRUGS AND THE TREATMENT OF VIRUS INFECTIONS**
June E. Osborn, MD, Madison

THURS., MAY 16: AFTERNOON SESSION

Three programs running concurrently

Anesthesiology

Moderator: FREDERICK D. COOK, MD, Green Bay

1. **ELECTRICAL HAZARDS IN HOSPITALS**
John M. R. Bruner, MD, Groton, Mass.

2. **PRESENT STATUS OF ELECTRO-ANESTHESIA**
Anthony Sances, PhD, Milwaukee

3. **PANEL DISCUSSION or BUSINESS MEETING OF SECTION**

Ophthalmology

Moderator: JAMES V. BOLGER, MD, Milwaukee

1. **TITLE PENDING**
J. Lawton Smith, MD, Coral Gables, Fla.

2. **PRESENTATION OF PAPERS FROM WISCONSIN PHYSICIANS**

3. **CLINICOPATHOLOGIC CONFERENCE**

Surgery

Moderator: BEN R. LAWTON, MD, Marshfield

1. **TITLE PENDING**
John S. Najarian, MD, Minneapolis, Minn.

(Balance of program is pending)

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1968–June 30, 1968

STATE DEPARTMENT OF PUBLIC INSTRUCTION

BUREAU FOR HANDICAPPED CHILDREN—CRIPPLED CHILDREN DIVISION

MADISON, WISCONSIN 53702

Location	*Date*
Manitowoc	February 28 and 29
Stevens Point	March 13
Ashland	March 14 and 15
Racine	March 20 and 21
Kenosha	March 27 and 28
La Crosse	April 3 and 4
Eau Claire	April 17 and 18
Superior	April 24
Rhinelander	May 1 and 2
Sheboygan	May 8 and 9
Chippewa Falls	May 22 and 23
Lancaster	June 5
Darlington	June 6

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicappel Children are for persons under 21 years of age who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examinations are sent to the referring physician following clinic.

REFERRAL FORMS: Referral forms may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for each clinic so when requesting same be sure to state how many forms are needed and for which clinic. It is important that we know well in advance the number desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 126 Langdon Street, Madison, Wisconsin 53702.

ANNUAL CLINICAL CONFERENCE
CHICAGO MEDICAL SOCIETY

FEBRUARY 25–28, 1968
Palmer House, Chicago

THIS CONFERENCE WILL BE OF INTEREST TO ALL PHYSICIANS. The program is presented by leaders of medical thought in all fields of medical activity. It is designed to interest the generalist and specialist alike. *THE OUTSTANDING LECTURE PROGRAM IS PLANNED TO KEEP US ABREAST OF SCIENTIFIC DEVELOPMENTS IN MEDICINE.* In addition certain sessions will take cognizance of socio-economic developments, all affecting the practice of medicine. All physicians, regardless of their field of interest, will find this program to be informative and useful.

For program or registration information address:

Clinical Conference Committee
Chicago Medical Society
310 South Michigan
Chicago, Illinois 60604

Announcing **THE THIRTY-FIRST ANNUAL MEETING OF**

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—Roosevelt Hotel—March 4, 5, 6, 7, 1968

GUEST SPEAKERS

Morris J. Nicholson, M. D., Boston, Mass.
ANESTHESIOLOGY
J. P. Nesselrod, M. D., Santa Barbara, Calif.
COLON AND RECTAL SURGERY
Robert W. Goltz, M. D., Denver, Colo
DERMATOLOGY
Charles H. Brown, M. D., Cleveland, Ohio
GASTROENTEROLOGY
George E. Burket Jr., M. D., Kingman, Kan.
GENERAL PRACTICE
J. George Moore, M. D., New York, N. Y.
GYNECOLOGY
William Dameshek, M. D., New York, N. Y.
INTERNAL MEDICINE
Oglesby Paul, M. D., Chicago, Ill.
INTERNAL MEDICINE
John A. Aita, M. D., Omaha, Neb.
NEUROLOGY
Robert B. Wilson, M. D., Rochester, Minn.
OBSTETRICS
Mack L. Clayton, M. D., Denver, Colo.
ORTHOPEDIC SURGERY
William H. Saunders, M. D., Columbus, Ohio
OTORHINOLARYNGOLOGY
Jon V. Straumfjord, Jr., M. D., Birmingham, Ala.
PATHOLOGY
Sydney S. Gellis, M. D., Boston, Mass.
PEDIATRICS
E. H. Schultz, Jr., M. D., Chapel Hill, N. C.
RADIOLOGY
Richard T. Shackelford, M. D., Baltimore, Md.
SURGERY
Kenneth W. Warren, M. D., Boston, Mass.
SURGERY
Laurence F. Greene, M. D., Rochester, Minn.
UROLOGY

Additional speaker to be announced.

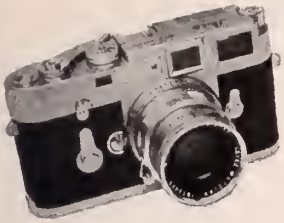
Lectures, symposia, clinicopathologic conference, round-table luncheons, medical motion pictures, technical exhibits, and entertainment for visiting wives.

(All-inclusive registration fee—$30.00)

This program is acceptable for thirty-two (32) elective hours by the American Academy of General Practice.

For information concerning the Assembly meeting write Secretary, The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

Pre-Assembly Special Symposium—Sunday, March 3—"Sexual Problems in Clinical Practice."



ANNUAL PHOTOGRAPHY CONTEST

OPEN TO MEMBERS OF THE STATE MEDICAL SOCIETY

EASY TO ENTER

Contest rules have been simplified to make it easier to enter your photographs.

Any black and white or color photo may be entered, either mounted, framed or unmounted. Photos may be enlarged to any size up to 16 x 20 inches, with a minimum recommended size of 5 x 7 inches.

Prizewinning photographs, if received unmounted, will be mounted on 16 x 20 boards for display at the State Medical Society Annual Meeting.

CLASSIFICATIONS

Medicine, Travel, People (at play and at work), Animals, Pictorial (landscape, objects, still life, etc.).

ENTRIES

There is no limit to the number of entries allowed to any exhibitor. All entries must be at the State Medical Society headquarters in Madison by April 1, 1968.

Entries must carry the following information on the back of the photo or mounting board: Title, class entered, name and address of exhibitor. There shall be no writing or printing on the front of the mounting board or any photo. All photos entered must be taken by the entrant but developing, enlarging and mounting need not be done by him.

AWARDS

Each division, black and white or color, will be judged separately and the following awards given to each classification: First place, second place and third place. In addition, three honorable mention awards will be given to each classification. There will be an award of "Best In Show" given to the best entry, either black and white or color. Trophies will be given to all first place winners and to the "Best In Show" and ribbons for all other awards.

JUDGING

Judging will take place prior to the showing of entries at the Annual Meeting. Winners will be notified of their awards as soon after judging as possible.

MAIL THIS ENTRY AND ALL PHOTOS TO:

PHOTO CONTEST, State Medical Society of Wisconsin,
Box 1109, Madison, Wis. 53701

Name _____

Address _____

CLASS	NUMBER ENTERED (Black & White)	(Color)	TOTAL
Medicine	_____	_____	_____
Travel	_____	_____	_____
People	_____	_____	_____
Animals	_____	_____	_____
Pictorial	_____	_____	_____

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A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: The Woman's Auxiliary to the State Medical Society of Wisconsin

CO-CHAIRMEN: Dr. and Mrs. Lawrence Larsen and Dr. and Mrs. Raymond Zastrow, Milwaukee

MILWAUKEE AUDITORIUM . . . MAY 13–16, 1968

Sculptures and Paintings (watercolors and oils only)

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or his **wife.**

LIMITED ENTRIES: Up to 3 entries per person.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be received on or before April 1, 1968. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)

REQUIREMENTS: (1) All pictures must be framed with wire and screw eyes attached. (2) Works of sculpture must not exceed 24 inches in height. (3) All entries must be delivered to the Dressing Room on the east side of the stage of Bruce Hall, Milwauwkee Auditorium between 8:00 a.m. and 10:00 a.m., Monday, May 13, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Thursday, May 16.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the three categories (sculpture, watercolor painting, oil painting) will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

NOTIFICATION OF INTENT TO EXHIBIT

Mail to Dr. and Mrs. Lawrence Larsen, 6520 N. Atwahl Drive, Milwaukee, Wis. 53209, BEFORE APRIL 1, 1968.

I plan to submit the following entry or entries for the 1967 MEDICAL ART SALON at the Milwaukee Auditorium, May 13–16.

My entry, or entries, will be:

(1) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(2) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(3) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(1) Sculpture __ Title _____ size _____" wide and _____" high

(2) Sculpture __ Title _____ size _____" wide and _____" high

(3) Sculpture __ Title _____ size _____" wide and _____" high

Name: _____ Street: _____

City: _____

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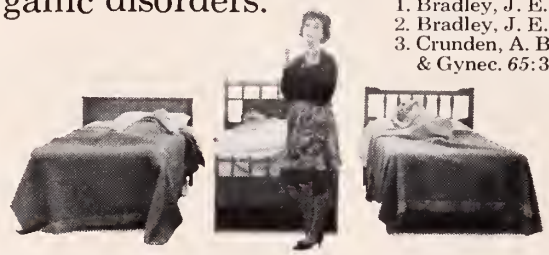
1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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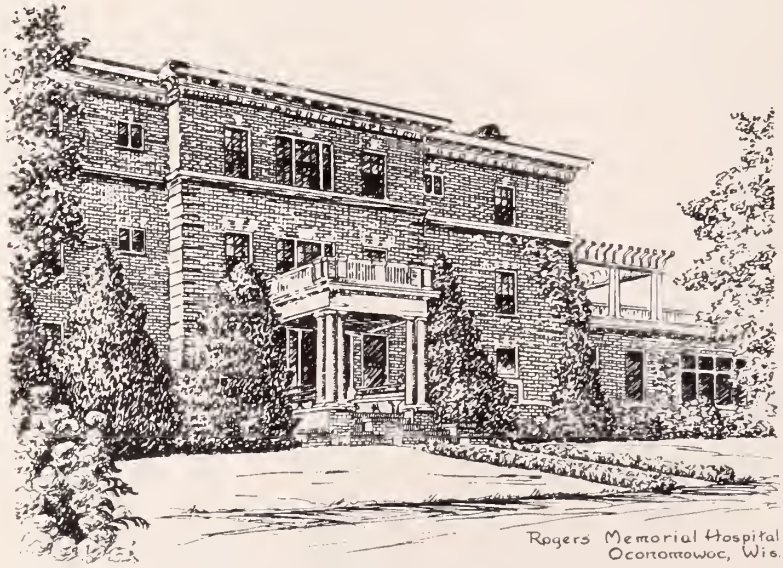

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director
EUGENE B. FRANK, M. D.
LOREN J. DRISCOLL, M. D.
THOMAS J. GORAL, M. D.
JOHN J. O'HARA, M. D.
EARL F. WEIR, M. D.
LEROY WAUCK, Ph. D.
Clinical Psychologist
ROBERT TESTIN, Ph. D.
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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF NOVEMBER 30, 1967

NEW MEMBERS

Aguilar–Sincaban, V.M., 301 Troy Dr., Madison 53704
Albright, John J., Marsh Clinic, Shawano 54166
Ali, Masroor, 710–12 North Webb Ave., Reedsburg 53959
Belber, Carl J., 1836 South Ave., La Crosse 54601
Biedlingmaier, Gerard J., 5900 South Lake Dr., Cudahy 53110
Bolman, William M., 1300 University Ave., Madison 53706
Burrill, Raymond E., 630 South Central Ave., Marshfield 54449
Connors, Charlotte B., 5618 Lake Mendota Dr., Madison 53705
Darling, Ronald J., V.A. Center, Wood 53193
Dawes, Robert B., N82 215401 Appleton Ave., Menomonee Falls 53051
Goswitz, John T., 601 North 8th St., Manitowoc 54220
Gundersen, Jerome H., 1836 South Ave., La Crosse 54601
Haug, Stephen L., 1836 South Ave., La Crosse 54601
Howard, Richard S., 1836 South Ave., La Crosse 54601
Keimowitz, Rudolph M., 1836 South Ave., La Crosse 54601
Kirkham, Bruce C., 2051 Allen Blvd., Middleton 53562
Mahairas, Gregory H., 1836 South Ave., La Crosse 54601
Manley, John C., 7635 W. Oklahoma Ave., Milwaukee 53219
Mathison, Johan A., 2257 North 64th St., Milwaukee 53213
McCay, Sophia, 235 North Madison St., Lancaster 53813
Mir, Ali A., 2219 Garfield St., Two Rivers 54241
Newcomer, Kermit L., 1836 South Ave., La Crosse 54601
Ozturk, Cahit H., 115 West 7th St., Neillsville 54456
Silverman, Carl, 30 South Henry St., Madison 53703
Smith, Martin J., 1836 South Ave., La Crosse 54601
Toyama, William M., 630 South Central Ave., Marshfield 54449
Tyson, Ian B., University Hospitals, Madison 53706
Wahl, Joseph W., 1836 South Ave., La Crosse 54601
Wasserburger, R. H., V.A. Hospital, Madison 53705
Zellmer, James H., 5148 North Teutonia Ave., Milwaukee 53209

CHANGES OF ADDRESS

Baldwin, Elizabeth A., Marshfield, to 841 North East Conway Blvd., Port Charlotte, Fla. 33950
Berg, James F., Hales Corners, to 3805 S. 48th St., Milwaukee 53220
Bergen, Paul M., 97 La Crosse St., Beaver Dam 53916
Borowski, T. P., 5757 West Oklahoma Ave., Milwaukee 53219
Calloway, Nathaniel D., 1103 Regent St., Madison 53715
Chapman, Marvin J., Portsmouth, New Hampshire, to Central State Hospital, Waupun 53963
Chpoyak, John A., Camp Pendleton, Calif., to Box 40, FPO San Francisco, Calif. 96695
Corcoran, William A., Jr., Port Washington, to 717 N. 113th St., Wauwatosa 53226
Danziger, Lewis, 1425 East Capitol Dr., Milwaukee 53211
Goerke, Robert F., Milwaukee, to Veterans Administration Hospital, Wood 53193
Greenwalt, Tibor J., Milwaukee, to American National Red Cross, Washington, D.C. 20006
Gursoy, Erdal Y., 1416 South Commercial, Neenah 54956
Heil, J. V., Milwaukee, to 16178 Martincoit Rd., Poway, Calif. 92064
Hein, W. E., Brodhead, to 2328 14th Ave., Monroe 53566
Himmelsbach, William A., La Crosse, to 5411 Sturgeon Creek Parkway, Midland, Mich. 48640
Holmen, Gerald J., 703 14th St., Baraboo 53913
Huewe, Douglas A., Milwaukee, to 1747 N. 74th St., Wauwatosa 53213
Humke, Everett W., Chilton, to 527 LaVerne St., Redlands, Calif. 92373
James, Richard L., Milwaukee, to 5854 South Packard Ave., Cudahy 53110
Kozelka, A. W., 1821 27th St., Two Rivers 54241
Lang, Gordon E., Milwaukee, to 5124 North Ardmore Ave., Whitefish Bay 53217
Lang, Jean L., Milwaukee, to 5124 North Ardmore Ave., Whitefish Bay 53217
Leering, Hendrick, Reedsville, to Lake Mills Medical Center, Lake Mills 53551
Litofsky, Arthur, Fort Lewis, Wash., to 3 Sugarbury Court, Reisterstown, Md. 21136
Llewellyn, M. B., P.O. Box 899, Janesville 53545
Mannis, Kent S., 5302 Fairway Dr., Madison 53711
May, James E., Bremerton, Washington, to Dept. of Pathology, U.S. Naval Hospital, Oakland, Calif. 94627
Oberfeld, Harold H., Milwaukee, to Judy Ann Apt. #7, 7207 Bay Drive, Miami Beach, Fla. 33141
Podruch, Philip E., Coralville, Iowa, to Child Education Center, 340 East Madison St., Louisville, Ky. 40202
Rapkin, Mitchell A., 810 Blue Ridge Parkway, Madison 53711
Reichle, Robert S., Clintonville, to 402 West Wisconsin Ave., Appleton 54911
Sarto, Gloria E., Madison, to Route 1, Middleton 53562
Schlichting, Johanna E., Sheboygan, to 4529 Bacon Ave., East, South St. Paul, Minn. 55075
Seay, Margaret J., Madison, to Winnebago State Hospital, Winnebago 54985
Seelman, J. J., 1616 West Bender, Milwaukee 53217
Siebert, John T., 703 14th Street, Baraboo 53913
Sorensen, Richard F., Box 408, West Bend 53095
Stein, R. W., Brookfield, to Route 1, Lake Five, Colgate 53017
Stenberg, Clayton C., Monroe, to Winston Bldg., Laconia, New Hampshire 03246
Stewart, Richard D., 8700 West Wisconsin Ave., Allen–Bradley Medical Science Laboratory, Milwaukee 53226
Stoddard, F. J., 4742 North Wilshire Rd., Milwaukee 53711
Verdone, Anthony J., 6815 West Capitol Dr., Milwaukee 53216
Wagner, George R., P.O. Box 428, Menomonee Falls 53051
Weber, C. J., 619 Highland Terrace, Sheboygan 53081
Wojcechowskyj, Stephan I., 5800 West National Ave., Milwaukee 53214
Wolf, Frederick H., Box 908, La Crosse, 54601

SOCIETY RECORDS *continued*

REMOVED FROM MEMBERSHIP

Angell, David C., Eau Claire–Dunn–Pepin County
Loken, Kenneth O., Eau Claire–Dunn–Pepin County
Sadd, John R., Dane County, transferred to Ohio
Solomon, Richard B., Dane County, resigned
Stein, Leonard I., Dane County, transferred to Kentucky
Wilkinson, Dudley E., Trempealeau–Jackson–Buffalo County, resigned
Auld, Irvin, Waupaca County
Barrett, David A., II, Milwaukee County, resigned
Benfield, John R., Dane County, transferred to California
Bowers, John Z., Dane County, resigned
Cooper, Thomas H., Rock County, removed per County Secretary
Cramer, Glen G., Polk County
Cutshall, Roger A., Barron–Washburn–Sawyer–Burnett County
Freeman, William S., Rock County
Himmelsbach, William A., La Crosse County, transferred to Michigan
Kuhs, Milton L., Brown County
LaHam, Jamil T., Fond du Lac County
Lefsrud, John B., La Crosse County, transferred to North Dakota
Ludwig, Arthur S., Polk County
McCann, John P., La Crosse County, transferred to Iowa
Mielke, Edward F., Outagamie County
Mills, E. Grady, Waukesha County
Mueller, Joseph F., Sheboygan County
Schmidt, Robert E., Milwaukee County
Shaw, Wesley R., Marathon County
Stephens, James P., Door–Kewaunee County
Terry, Robert E., Grant County
Thomson, George H., Rock County

DEATHS

Felton, William Carl, nonmember, Oct. 5, 1967
Nowack, Louis H., nonmember, Oct. 22, 1967
Corcoran, Cornelius J., Milwaukee County, Oct. 24 1967
Kolb, Frederick K., Sheboygan County, Nov. 3, 1967
Bailey, Douglas W., Milwaukee County, Nov. 4, 1967
Schweitzer, George J., Milwaukee County, Nov. 7, 1967
Moore, Robert M., Polk County, Nov. 21, 1967

SERVICES TO PHYSICIANS AND THE PUBLIC

from the

PUBLIC INFORMATION DEPARTMENT OF THE STATE MEDICAL SOCIETY

The following services are provided to member physicians and the general public, under the direction of the Commission on Public Relations and Communications—a standing committee of the Council. For the most part they are designed to assist the physician in preparing for participation in health education events such as speeches to non-medical audiences, or to provide factual health information directly to the general public. Address requests, or have your patients write: Public Information Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LOAN PACKETS

Packets of reference materials are provided, on a loan basis, on such topics as Fluoridation, Establishing a Practice, Health Fads and Fallacies, Alcoholism, Health Careers, Emotional Aspects of Malignancy, and numerous others.

FILM SERVICE

An index of films, suitable for both medical and non-medical audiences, is maintained by the Society. Please be as specific as possible concerning the desired topic. Since the Society does not maintain a film library and all films must be ordered from another source, two weeks notice is desirable. Cost normally involves only return postage, however in some cases there is a rental or service charge to be paid by the recipient.

HEALTH CAREERS MATERIALS

Materials on careers in medicine are available as references for physicians participating in Career Days and leaflets are available in quantity for distribution to groups. Reference materials on careers ancillary to medicine, and sources of loans and scholarships are also available.

HEALTH EDUCATION LITERATURE

Single pamphlets are available on a wide range of topics for individuals seeking factual information on health.

MOUTH-TO-MOUTH BREATHING AND CLOSED CHEST CARDIAC MASSAGE

Films and a demonstration manikin are available for special programs on mouth-to-mouth breathing and closed chest cardiac massage. The latter topic is considered appropriate for physicians, nurses, policemen, firemen and rescue personnel, and requires supervision of a physician trained in the technique.

SPEAKERS SERVICE

While it is normally desirable to have a local physician fulfill speaking engagements in his community, speakers are available on the state level where a special topic or audience size makes it desirable.

Recent Wisconsin Licentiates

The following physicians were granted licenses by oral and written examination by the State Board of Medical Examiners at a meeting in Madison, January 10–12, 1967.

Name	*School of Graduation*	*Year*	*City*
Apte, Upendra S.	Kasturba Medical College	1959	Milwaukee
Bach, Philip J.	University of Wisconsin	1966	Charlotte, N. C.
Atassi, Safouh A.,	Syrian University	1955	Shullsburg
Bohigian, George M.	St. Louis University	1965	St. Louis, Mo.
Barnes, Haldor P. G.,	University of Wisconsin	1966	Madison
Chandler, John W., Jr.	University of Wisconsin	1965	Shawnee Mission, Kan.
Collins, Deirdre S.	University of Chicago	1965	Maxwell AFB, Ala.
Da Cunos, Guillermo, Jr.	University of Philippines	1956	Madison
Denius, Larry R.	University of Wisconsin	1964	Hot Springs, Va.
Fodor, Peter B.	University of Wisconsin	1966	Dallas, Tex.
Grauel, Truman W.	University of Wisconsin	1966	Overland Park, Kan.
Habel, Theodor	University of Wisconsin	1966	Westby
Katz, Richard H.	University of Wisconsin	1966	Tohatchi, N. M.
Hedican, Robert E., Jr.	University of Wisconsin	1966	Eau Claire
Johnson, George K.	University of Utah	1965	Salt Lake City, Utah
Kehm, Joseph C.	University of Wisconsin	1964	South Miami, Fla.
Konz, Fredric S.	University of Wisconsin	1966	Madison
Lundberg, Kay R.	University of Wisconsin	1966	Warm Springs, Ore.
Lundberg, William I.	University of Wisconsin	1966	Warm Springs, Ore.
Malit, Benito B.	Manila Central University	1958	Delavan
Martalock, Dean L.	University of Wisconsin	1966	Rochester, Minn.
Molina, Rodolfo,	University of Santo Tomas	1959	Beaver Dam
Phillips, Stanley M.	University of Wisconsin	1966	Philadelphia, Pa.
Najat, Hushang,	University of Tabriz	1957	Monroe
Pimentel, Esperanza M.	University of Santo Tomas	1954	St. Louis, Mo.
Raduege, William E.	University of Wisconsin	1966	Bruce
Santilli, Robert J.	University of Wisconsin	1966	Milwaukee
Rustia, Ricardo M., Jr.	University of Santo Tomas	1957	Elgin, Ill.
Silberman, Richard E.	University of Wisconsin	1966	Milwaukee
Rafiullah, Mohammed	Liqat Medical College	1956	Racine
Stien, Kim Patrick	University of Wisconsin	1966	Stevens Point
Strang, Paul J.	University of Wisconsin	1966	Grantsburg
Sykes, W. Stuart	University of Oxford	1955	Madison
Wagnild, Jon P.	University of Pennsylvania	1965	Madison
Weinberg, David L.	University of Wisconsin	1966	Milwaukee
Whitecotten, Glenn L.	University of Wisconsin	1966	Cleveland, Ohio

The following physicians were granted licenses by oral and written examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 11–13, 1967

Name	*School of Graduation*	*Year*	*City*
Agarwal, Avadh B.	University of Lucknow	1954	Milwaukee
Aguilar-Sincaban, Virginia,	University of Philippines	1957	Madison
Akture, Mehmet A.	Medical Faculty of Ankara	1957	Hazel Green
Ali, Masroor, M. D.	University of Karachi	1957	Reedsburg
Anderson, Craig L.	University of Wisconsin	1966	Rochester, N. Y.
Anderson, James L.	University of Wisconsin	1966	Madison
Ansfield, Thomas J.	University of Wisconsin	1966	Madison
Aquino, Edmundo C.	University of Santo Tomas	1959	Monticello
Armagan, Senekerim	University of Istanbul	1958	Chicago, Ill.
Atamdede, Yasar I.	University of Istanbul	1950	Milwaukee
Banda, Pedro N.	University of Cartagena	1960	Chicago, Ill.
Barnes, Francis E.	University of Western Ontario	1960	Columbus, Ohio
Berman, Robert L.	University of Wisconsin	1966	Milwaukee
Betts, Lawrence T.	University of Wisconsin	1966	Milwaukee
Bhore, Jayawant N.	Byramjee Jeejeebhey	1944	Chicago, Ill.
Burgoyne, Frederick H.	University of Manitoba	1945	Marshfield
Burpee, James F.	University of Wisconsin	1966	Madison
Busse, William W.	University of Wisconsin	1966	Madison
Capati, Nazario R.	Manila Central University	1959	Neillsville
Chiles, John A.	University of Pennsylvania	1966	Madison
Co, Anthony	University of Santo Tomas	1956	Milwaukee
Dalil, Vincent H.	University of Wisconsin	1966	Winnebago
D'Amato, James M.	University of Wisconsin	1966	Hampton, Va.
Diddams, John A.	University of Wisconsin	1966	Madison
Eisele, John E.	University of Wisconsin	1965	Madison
Gomilla, Severino G.	University of Santo Tomas	1956	Kenosha
Grossenbacher, Edward A.	University of Oregon	1964	Milwaukee
Hagen, Kent E.	University of Wisconsin	1966	San Francisco, Calif.

continued on next page

WISCONSIN LICENTIATES *continued*

Name	*School of Graduation*	*Year*	*City*
Hegedus, Alexander S.	University of Wisconsin	1965	Balboa Heights, Canal Zone
Herrmann, Richard A.	University of Wisconsin	1966	Milwaukee
James, Paul G.	University of Wisconsin	1966	San Francisco, Calif.
John, James Louis	University of Wisconsin	1966	Waukesha
Josephson, Thomas S.	University of Wisconsin	1966	Madison
Kirkham, Bruce C.	University of Wisconsin	1966	Middleton
Kniaz, Harry	University of Wisconsin	1966	Ft. Walton Beach, Fla.
Langhus, Peter A.	University of Wisconsin	1966	FPO San Francisco, Calif.
Livingston, John G.	University of Wisconsin	1966	Staten Island, N. Y.
Lim, Robert A.	University of Santo Tomas	1955	Bismarck, N. D.
Mirshahidi, Massoud	University of Tehran	1952	Monroe
Neal, David A.	University of Wisconsin	1966	FPO New York
Nibler, James G.	University of Wisconsin	1966	Tomahawk
Paetkau, Margaret E.	University of Wisconsin	1966	Madison
Pamukcu, Afet	University of Istanbul	1951	Kenosha
Quisling, Stewart W.	University of Wisconsin	1966	Cleveland, Ohio
Reyes, Metodio M.	University of Santo Tomas	1956	Elgin, Ill.
Reynolds, James Carter	University of Wisconsin	1966	Rochester, Minn.
Riemer, Donald E.	University of Wisconsin	1966	Rochester, Minn.
Siedband, Gerald N.	University of Basel	1965	Milwaukee
Smuckler, Mark B.	University of Wisconsin	1966	Milwaukee
Tanrikulu, Orhan	University of Istanbul	1955	Chicago, Ill.
Tibbetts, Jay J.	University of Wisconsin	1966	Green Bay
Wiatr, Kusum C.	All India Institute of Medical Science	1961	Berwyn, Ill.
Wilmet, Jean	Free University of Brussels	1959	Madison
Zondlo, Joseph G.	University of Wisconsin	1966	Upper Darby, Pa.
Pfaehler, G. Thomas	University of Wisconsin	1966	Madison

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, October 11 and 12, 1967.

Name	*School of Graduation*	*Year*	*City*
Ames, Arthur	University of Pennsylvania	1963	Pewaukee
Barnes, Gerald C.	University of Wisconsin	1965	Middleton
Belber, Carl J.	University of Pennsylvania	1958	La Crosse
Blackwood, John S.	Marquette University	1964	Milwaukee
Brent, Burton D.	Chicago Medical School	1963	Madison
Browell, John N., Jr.	University of Maryland	1961	Marshfield
Cicero, James J.	Northwestern University	1963	River Falls
Crawford, William A.	University of Iowa	1959	Oshkosh
Cullinan, John P.	University of Illinois	1955	Aurora, Ill.
Donahue, Parnell	Marquette University	1964	Wauwatosa
Faber, John Wm.	Northwestern University	1964	Rochester, Minn.
Friedman, Gary D.	Ohio State University	1964	Milwaukee
Gilmor, Richard L.	Ohio State University	1965	Milwaukee
Giorgini, Gino L., Jr.	New Jersey College of Medicine	1966	Wauwatosa
Glazier, Edward H.	George Washington University	1957	Waukesha
Grais, Ira M.	University of Illinois	1964	La Grange Park, Ill.
Hillegas, Jon R.	University of Cincinnati	1964	Milwaukee
Hussey, John L.	University of Colorado	1966	Madison
Karofsky, Peter S.	Tufts University	1966	Middleton
Klein, Martin H.	University of Wisconsin	1948	Chilton
Larkin, Edwin R.	University of Wisconsin	1962	Madison
Lewis, John L.	Johns Hopkins University	1944	Milwaukee
Madden, James A.	Marquette University	1966	Milwaukee
Masouredis, Serafeim P.	University of Michigan	1948	Milwaukee
Masukawa, Teruo	Nagoya University	1952	Milwaukee.
Murphy, Leo J.	Marquette University	1964	Milwaukee
Mykytew, Marion	University of Michigan	1946	Milwaukee
Nelson, Donald R.	University of Illinois	1964	Wauwatosa
Novak, Clarence G.	University of Illinois	1944	Michigan City, Ind.
O'Mara, Michael G.	University of Oregon	1966	Milwaukee
Quackenbush, Robert P.	University of Illinois	1952	Milwaukee
Richards, Melvin J.	University of Iowa	1966	Madison
Robinhold, Daniel G., III	Johns Hopkins University	1965	Madison
Roe, Patrick A.	Marquette University	1964	Milwaukee
Seiple, George W.	Emory University	1957	Madison
Shambaugh, George E., III	Cornell University	1958	Sun Prairie
Silverman, Elizabeth B.	Harvard Medical School	1962	Madison
Skibba, Carla Ann	Marquette University	1967	Madison
Theobald, Sterling	Indiana University	1956	Waukesha
Varberg, Bernard M.	Temple University	1964	Wauwatosa
Wood, Frances E.	University of Cincinnati	1947	Madison
Wood, John Thornton	University of Virginia	1955	Madison
Wrigley, John B.	Temple University	1964	River Falls

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 12, 1967.

Name	*School of Graduation*	*Year*	*City*
Apfelberg, David B.	Northwestern University	1966	Milwaukee
Bahr, Robert D.	George Washington University	1954	West Allis
Barr, Arlene N.	Western Reserve University	1966	Madison
Batayias, George E.	Medical College of Georgia	1960	Milwaukee
Belden, Allan D.	University of Minnesota	1961	Appleton
Belknap, Benjamin H.	University of Rochester	1961	Milwaukee
Benforado, Joseph M.	State University of New York	1951	Madison
Bernie, Jan E.	Indiana University	1964	Milwaukee
Best, John D.	University of Illinois	1959	Manitowoc
Bittar, Neville	McGill University	1961	Madison
Boeke, Larry H.	University of Iowa	1963	West Union, Iowa
Bourne, Charles W.	University of Michigan	1959	Milwaukee
Bowman, John W.	University of Cincinnati	1966	Milwaukee
Brueggemann, Martin W.	University of Cincinnati	1966	Madison
Buss, Robert O.	Marquette University	1966	Milwaukee
Carpenter, Clarence J.	Ohio State University	1954	Orient, Ohio
Cesarz, Thomas J.	Marquette University	1966	Milwaukee
Chan, Gregory Kowk-Kay	Marquette University	1966	Milwaukee
Clowry, Lawrence J., Jr.	Johns Hopkins University	1959	Brookfield
Conklin, John Williams	Washington University	1963	Waukesha
Cozine, Winston I.	University of Oregon	1959	Kenosha
Dagon, Eugene M.	Marquette University	1966	Kenosha
Daines, Sheridan L.	George Washington University	1965	West Allis
D'Alessio, Donn J.	Cornell University	1960	Madison
Davis, Hugh L., Jr.	University of Chicago	1954	Madison
deMaine, James B.	University of Pennsylvania	1964	Madison
Dieruf, William J.	Washington University	1965	Wauwatosa
Dietsche, Wolfgang O. W.	Albert Ludwigs University	1951	Urbana, Ill.
Dominguez, Oscar	University of Antioquia	1958	Marshfield
Donovan, William H.	Albany Medical College	1966	Wauwatosa
Dorff, Gerald J.	Marquette University	1964	Milwaukee
Doty, Joseph M.	Marquette University	1964	Milwaukee
Engelbrecht, Frederick	Marquette University	1962	Madison
Etzwiler, Donnell D.	Yale Medical School	1953	Minneapolis, Minn.
Foreman, John W.	Yale University	1962	Racine
Garcia, Arthur F., Jr.	University of Illinois	1966	Milwaukee
Gierasinski, Stanislaw	University of Wilno	1938	Downey, Ill.
Gilbert, Kenyon R.	University of Illinois	1964	Durand, Ill.
Grogan, John P.	Marquette University	1966	Milwaukee
Gulyn, Bohdan E.	Vienna Medical College	1940	Wausau
Hartman, Bruce H.	Marquette University	1966	Milwaukee
Hassler, Robert E.	New York Medical College	1960	Monroe
Holzwarth, David R.	Northwestern University	1962	Chicago, Ill.
Huberty, Lee H.	Marquette University	1966	Wauwatosa
Irvin, Ronald K.	University of Cincinnati	1966	Wurtsmith AFB, Mich.
Janusonis, Palmira A.	University of Illinois	1966	Milwaukee
Jarrett, James E.	University of Rochester	1964	Brookfield
Jensen, Norman M.	University of Wisconsin	1965	Libertyville, Ill.
Kauffman, Herbert M., Jr.	Medical College of Virginia	1958	Elm Grove
Keimowitz, Rudolph M.	University of Vermont	1961	La Crosse
Kilness, Arthur W.	University of Louisville	1947	Oconomowoc
Kingham, James D.	Indiana University	1966	Milwaukee
Kirsch, John M.	University of Illinois	1964	New Berlin
Klein, Robert L.	Marquette University	1966	Akron, Ohio
Lavine, Daniel	Ohio State University	1960	Milwaukee
Layton, Caleb R., Jr.	University of Pennsylvania	1964	Madison
Lent, John E.	Georgetown University	1966	Milwaukee
Levy, Robert M.	Northwestern University	1964	Madison
Lewis, James M.	Marquette University	1966	Milwaukee
Lichty, James E.	University of Iowa	1962	Wauwatosa
Loescher, Albert W.	University of Cincinnati	1966	Wauwatosa
Lopez, Basilio	University of Madrid	1952	Milwaukee
Margolis, Marvin H.	University of Miami	1966	Madison
Martin, Donald C., Jr.	University of Pennsylvania	1962	Wisconsin Dells
Martins, Ronald R.	Creighton University	1964	Milwaukee
Matsis, John P.	Indiana University	1962	Milwaukee
Mayhew, Duane G.	University of Saskatchewan	1966	Milwaukee
McCarthy, Mary D.	Western Reserve University	1966	Milwaukee
McCay, Sophia P.	University of Colorado	1959	Lancaster
Miller, Marvin D.	University of California	1959	Wauwatosa
Monroe, Kent M.	University of Illinois	1964	Wauwatosa
Monroe, Mildred L.	University of Illinois	1965	Wauwatosa

continued on next page

WISCONSIN LICENTIATES *continued*

Name	*School of Graduation*	*Year*	*City*
Moretti, Joseph A.	University of Chicago	1966	Milwaukee
Mueller, Mark N.	Columbia University	1959	Madison
Nesemann, Sam P.	Marquette University	1964	Milwaukee
Newcomer, Kermit L.	Western Reserve University	1959	La Crosse
O'Connor, Thomas A.	Marquette University	1966	Milwaukee
Ozturk, Cahit H.	University of Istanbul	1943	Neillsville
Pacanowski, Roger T.	University of Iowa	1966	Milwaukee
Pamintuan, Rogelio V.	University of Philippines	1960	Milwaukee
Perlman, Lawrence V.	Yale University	1961	Ann Arbor, Mich.
Pinkerton, John D.	George Washington University	1960	Menominee, Mich.
Raich, Peter C.	University of Wisconsin	1964	Madison
Reichert, Henry L., Jr.	Marquette University	1966	Wauwatosa
Reinardy, Michael J.	Marquette University	1966	Janesville
Riabov, Sviatoslav	University of Strasbourg	1956	Superior
Rosenbaum, Thomas W.	Northwestern University	1966	Milwaukee
Rosenthal, Dorothy L.	University of Kansas	1966	Milwaukee
Rosenthal, Sheldon A. E.	University of Kansas	1966	Milwaukee
Rowe, David L.	Middlesex University	1945	Pompano Beach, Fla.
Rust, Garry F.	Creighton University	1964	Franksville
Scherping, Steven C.	University of Rochester	1963	Wauwatosa
Schneble, William J.	Marquette University	1964	West Allis
Schneider, J. Morton	University of Michigan	1960	Madison
Schwartz, Henry J. C.	University of Wisconsin	1965	FPO San Francisco 96601
Selden, John F.	University of Michigan	1964	Madison
Seward, Robert L.	University of Wisconsin	1966	Berlin
Shaffer, Robert D.	University of Illinois	1964	Shorewood
Shapior, Ivan L.	Ohio State University	1966	Milwaukee
Silverman, Carl G.	Harvard Medical College	1960	Madison
Spiegelhoff, Don R.	Marquette University	1966	West Allis
Stakem, Brian E.	Medical College of Virginia	1966	Milwaukee
Steinhaus, Brian T.	Marquette University	1966	Milwaukee
Stram, Thomas Wm.	University of Wisconsin	1964	Milwaukee
Sullivan, Kay R.	Woman's Med. College of Pennsylvania	1966	Milwaukee
Tamisiea, J. Richard	Creighton University	1964	West Allis
Thimmesch, Michael J.	Marquette University	1966	Milwaukee
Toyama, William M.	University of Michigan	1957	Marshfield
Veenhuis, Philip E.	University of Michigan	1961	Wauwatosa
Viste, Kenneth M., Jr.	Northwestern University	1966	Sturgeon Bay
Vitale, Leonard F.	Seton Hall College	1964	Madison
Wagner, Thomas R.	Marquette University	1966	Milwaukee
Wahl, Joseph W.	University of Tennessee	1957	La Crosse
Wannamaker, Braxton	Medical College of South Carolina	1966	Madison
Weeks, Ralph H.	Indiana University	1966	Milwaukee
Witt, Raymond W.	University of Illinois	1966	Wauwatosa
Zerella, Joseph T.	Northwestern University	1966	Milwaukee
Zimmer, John F.	Indiana University	1964	Madison
Zimmerman, Richard C.	Marquette University	1966	Milwaukee
Zimmerman, Stephen W.	University of Wisconsin	1966	Madison
Zizic, Thomas M.	Johns Hopkins University	1965	Milwaukee
Holm, William A.	University of Minnesota	1966	Antigo

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CONTENTS

Vol. 67, No. 2 FEBRUARY 1968

SCIENTIFIC ARTICLES

Symposium: The Geriatric Patient—Profile of the Aged; introduction, by Jesse J. Barron, M.D., Minneapolis, Minn. ---------- 113

The Geriatric Patient and the Physician, by Jesse J. Barron, M.D., Minneapolis, Minn. - 114

Physician–Patient Relationship in Geriatric Treatment, by James L. Elmore, M.D., Durham, N. C. ---------- 117

Neurologic Problems of the Aged, by Francis M. Forster, M.D., Madison ---------- 121

Psychiatric Morbidity of Physicians; summary, by John C. Duffy, M.D. and Edward M. Litin, M.D., Rochester, Minn. ---------- 125

The Geriatric Patient; case report, by Robert N. Leasum, M.D., Osseo ---------- 126

Therapeutic Dilemmas (No. 4 of a series): Primary Myocardial Disease, by Harry Beckman, M.D., Milwaukee ---------- 128

Comments on Treatment: Complexities of Drug Therapy in Medical Practice, by Richard I. H. Wang, Ph.D., M.D., Milwaukee ---- 133

SPECIAL FEATURES

Tentative Scientific Program, State Medical Society Annual Meeting, May 14–16, Milwaukee ---------- 13

Annual Photography Contest, 1968 Annual Meeting ---------- 28

Medical Art Salon, 1968 Annual Meeting -- 29

Wisconsin's Health: Many Health Workers Enter Battle on PKU, by E. H. Jorris, M.D., State Health Officer ---------- 120

Pathogenesis of the Sporadic Case of Tuberculosis (abstract) ---------- 127

A New Co-Editor for "Comments on Treatment": Richard I. H. Wang, Ph.D., M.D. - 134

What the Extended Care Facility Expects from the Physician and the Nurse, by the Reverend C. A. Becker, D.D., Racine ------ 136

Dial Access Medical Library ---------- 40

Milwaukee Institutions Coordinate Medical Services for Ill and Handicapped Children 54

Medical Self-Help Humanitarian Award ---- 70

EDITORIALS

President's Page: The Blue Plans—A Plea, by Harold J. Kief, M.D., Fond du Lac ------ 139

Medical Public Utility ---------- 141

Accurate Recognition ---------- 142

Conference on Quackery ---------- 142

REGULAR FEATURES

Publication Information ---------- 7

County Medical Societies: Presidents and Secretaries ---------- 8

Medical Meetings ---------- 10

Wisconsin Physicians Service ---------- 18

Letters ---------- 144

Section on Ophthalmology ---------- 145

The Medical Student Forum ---------- 146

January at Society Headquarters --------- 31

News of Wisconsin Physicians ---------- 33

County Society Proceedings ---------- 43

Specialty Society Proceedings ---------- 45

Paramedical/Ancillary Groups ---------- 51

Obituaries ---------- 71

Society Records ---------- 79

Physicians Exchange ---------- 82

Index to Advertisers ---------- 84

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ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.

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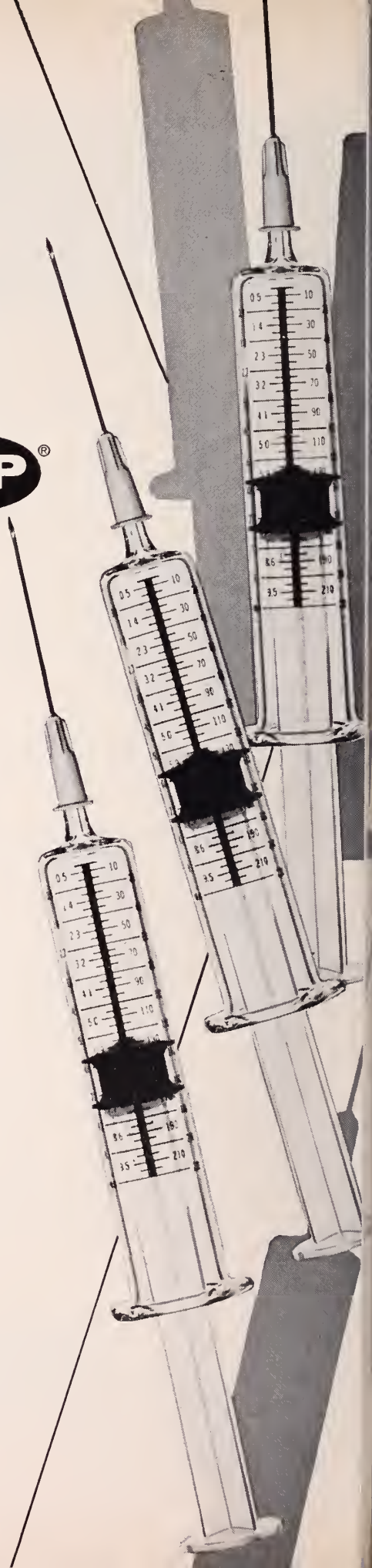

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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 WISCONSIN

Mar. 4: Postgraduate course, "Hypoglycemias in Infants and Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11: Postgraduate course, "Etiology and Management of Nephrosis in Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11–22: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Mar. 18: Postgraduate course, "Prevention of Mental Retardation," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 23: Town and Gown Symposium, State Medical Society of Wisconsin, Madison.

Mar. 25: Postgraduate course, "Emotional Crises Among Adolescents," sponsored by Marquette University, Milwaukee.

Mar. 27–28: Third Annual Sports Medicine Conference, University of Wisconsin Medical Center and Extension, Madison.

Apr. 4–5: Wisconsin Anti-Tuberculosis annual meeting, Milwaukee.

Apr. 4–6: Symposium on "Fetal Medicine," Department of Pediatrics, University of Wisconsin Medical Center, Madison.

Apr. 18–19: Conference for Directors of Nursing in Small Hospitals, University Extension, Marshfield.

Apr. 19: Sixth annual cancer conference for nurses: "Nursing Care of the Cancer Patient," Union Theater, Madison UW Campus, University Extension in cooperation with Wisconsin Division of American Cancer Society.

Apr. 22–24: 98th annual session, Wisconsin State Dental Society, Milwaukee Auditorium, Milwaukee.

Apr. 22–May 3: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

May 9–10: Conference for Directors of Nursing in Small Hospitals, University Extension, Madison.

May 14–16: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June 7–9: Meeting of Wisconsin Society of Pathologists, "Pitfalls in Dermapathological Diagnosis" by Dr. Arthur C. Allen. (Location undetermined)

Sept. 14–15 (tentative): Fall meeting, Wisconsin Otolaryngological Society.

Sept. 21: Fall meeting, Wisconsin Surgical Society, St. Mary's Hospital, Madison.

Sept. 12–14: Fall meeting, Wisconsin Society of Internal Medicine, Oshkosh, at The Pioneer.

Sept. 14–15: Fall meeting, Wisconsin Society of Anesthesiologists, Lake Geneva, at the Playboy Club.

Sept. 20–22: Fall meeting, Wisconsin Radiological Society, Lake Geneva, at the Playboy Club.

Sept. 25–26: Annual meeting, Wisconsin Academy of General Practice, Pfister Hotel, Milwaukee.

Oct. 8–11: Meeting of the Wisconsin Nurses Association, Sheraton-Schroeder Hotel, Milwaukee.

Oct. 9–10: Meeting of Wisconsin Division, American Cancer Society, Oshkosh.

Nov. 16: Annual meeting, Wisconsin Society of Pathologists. (Location undetermined)

1968 NEIGHBORING STATES

Mar. 7–8: "The Doctor and His Hospital," Workshop, The Institute of Medicine of Chicago, Pick-Congress Hotel, Chicago, Ill.

Mar. 14–16: "The Clinical Selection of Patients for Cardiac Surgery, American College of Physicians, Mayo Graduate School of Medicine (University of Minnesota) and Mayo Clinic, Rochester, Minn.

Mar. 25–Apr. 6: Postgraduate course in Laryngology and Bronchoesophagology, Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, Ill.

Apr. 17–20: 12th annual postgraduate course on Fractures and Other Trauma, Chicago Committee on Trauma of the American College of Surgeons, John B. Murphy Memorial Auditorium, Chicago, Ill.

Apr. 22–26: "Clinical Endocrinology—Recent Advances in Diagnosis and Treatment," American College of Physicians, Mayo Graduate School of Medicine (University of Minnesota) and Mayo Clinic, Rochester, Minn.

Apr. 29–May 1: 38th annual Tri-State Hospital Assembly, Palmer House, Chicago, Ill.

May 2–3: Scientific sessions, Illinois Heart Association, Springfield, Ill.

May 2–4: "Prevention in Cardiology," Minnesota Heart Association and the Mayo Clinic, Rochester, Minn.

May 10–11: "Electrophysiology and Electrocardiography," Michigan Heart Association, Detroit, Mich.

June 10–14: "Internal Medicine," American College of Physicians, University of Iowa School of Medicine, Iowa City, Ia.

Sept. 26–29: "The Metabolic Basis of Heart Disease," American College of Physicians, Wayne State University School of Medicine, Detroit, Mich.

Oct. 12–18: Annual Otolaryngologic Assembly of 1968, Illinois Eye and Ear Infirmary at the Medical Center, Chicago, Ill.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

1968 OTHERS

Mar. 4–7: New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.

Apr. 17–18: University of Colorado School of Medicine postgraduate course: "Management and Care of Respiratory Insufficiency," Humphreys Postgraduate Center, Denver, Colo.

Apr. 21–27: Interamerican Congress of Cardiology, Lima, Peru.

Apr. 22–25: American Industrial Health Conference, Hilton Hotel, San Francisco, Calif.

May 4–9: Annual teaching seminar, International Academy of Proctology, Montreux-Palace Hotel, Montreux, Switzerland.

May 13–17: Annual meeting, Ohio State Medical Association, Cincinnati, the Netherland Hilton Hotel.

June 19: Joint Session of the American College of Cardiology with the Section of Internal Medicine of the American Medical Association and the American Heart Association, AMA Annual Meeting, San Francisco, Calif.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo.

Sept. 28–Oct. 3: Western Hemisphere Congress, International College of Surgeons, Honolulu, Hawaii.

Oct. 6–11: XVI Biennial International Congress, International College of Surgeons, Tokyo, Japan.

Oct. 16–26: Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, International College of Surgeons.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

Oct. 26–Nov. 11: Around-the-World Postgraduate Clinics, International College of Surgeons, India, Egypt, Holy Land, Israel, and Greece.

Nov. 19–20: 22nd Annual Meeting, American Heart Association Council on Arteriosclerosis, Bal Harbour, Fla.

Nov. 21–24: 41st Scientific Sessions, American Heart Association, Bal Harbour, Fla.

Nov. 25–26: Annual Assembly Meeting, American Heart Association, Bal Harbour, Fla.

1969 OTHERS

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

1968 AMA

Mar. 29–30: National Conference on Rural Health, Olympic Hotel, Seattle, Wash.

June 16–20: 117th Annual Convention, San Francisco, Calif.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Postgraduate Medical Education, Colorado

The University of Colorado School of Medicine, Denver, has announced the following postgraduate courses:

Apr. 15–19: HIGH RISK INFANT CARE

Apr. 17–19: RESPIRATORY INSUFFICIENCY

Apr. 25–27: CLINICAL DERMATOLOGY

June 17–19: INTENSIVE CARE UNITS (American College of Physicians)

June 17–20: OBSTETRICS AND GYNECOLOGY (Estes Park)

July 8–11: OPHTHALMOLOGY (Estes Park)

July 15–18: MEDICAL RECORD LIBRARIAN CONFERENCE (Estes Park)

July 21–27: FOURTEENTH ANNUAL GENERAL PRACTICE REVIEW

Aug. 1–3: DERMATOLOGY (Aspen)

Aug. 5–8: PEDIATRICS (Aspen)

Aug. 12–16: INTERNAL MEDICINE (Estes Park)

Sept. 30-Oct. 4: HOSPITAL MEDICAL STAFF CONFERENCE (Estes Park)

Oct. 7–11: HIGH RISK INFANT CARE

For further information contact: The Office of Postgraduate Medical Education, U of C School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

Fractures and Other Trauma, Chicago

From April 17–20, the Chicago Committee on Trauma will present its Twelfth Postgraduate Course on Fractures and Other Trauma. It will attempt to cover many aspects of injuries. This includes abdominal, thoracic, genito–urinary, ophthalmologic, neurosurgical, and vascular trauma, as well as musculo–skeletal trauma.

On the evening of April 18, 1968, the Chicago Committee on Trauma will collaborate with the Chicago Metropolitan Chapter of the American College of Surgeons in presenting a program dealing with tornado injuries. This program will be moderated by Dr. Jackson.

Other panel discussions will be presented and will deal with athletic injuries and with thermal injuries. The latter subject will be presented by Dr. John Boswick, with panelists Allen R. Dimick, M.D., Birmingham, Ala.; Nelson H. Stone, M.D., Chicago, Ill.; and Charles Baxter, M.D., of Dallas, Texas.

It is planned also to present some aspects of military surgery as seen recently in Vietnam, and to cover some aspects of civilian injuries in that same locale.

The four-day course will be given at the John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago 60611. The course is open to all doctors. Registration fee, which is $80.00, includes the Chairman's reception one evening, and luncheon at the Kungsholm Restaurant on one of the meeting days. Residents and interns will be admitted free upon presentation of a letter from their chief of service. The American Academy of General Practice gives credits to members who take the course. Registration can be accomplished by writing to James P. Ahstrom, Jr., M.D., Chairman, Twelfth Post Graduate Course, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611. Reservations at one of the many nearby hotels should be made individually and separately.

TOWN AND GOWN SYMPOSIUM

Sponsored by the State Medical Society of Wisconsin

at Society Heaquarters in Madison
330 East Lakeside Street

Saturday, March 23, 10 a.m.

Theme: *Delivery of Medical Services and the Teaching of Medicine*

Participants

JAMES L. DENNIS, M.D.
Vice-president and Dean, The University of Oklahoma Medical Center, Oklahoma City

Title: *Does Medical Education Have a Role in the Delivery of Health Services?*

JOHN H. MOXLEY, III, M.D.
Assistant to the Dean, Harvard Medical School, Boston, Mass.

Title: *Can Delivery of Health Services Be Utilized in Medical Education?*

THIRD SPEAKER PENDING

The afternoon session will be broken into four or five small discussion groups. The groups will join again about 4 p.m. for a windup and conclusion of the program.

A Postgraduate Education Program under the direction of the State Medical Society's Commission on Hospital Relations and Medical Education with support of the Society's Charitable, Educational and Scientific Foundation.

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MEDICAL MEETINGS *continued*

Annual Otolaryngologic Assembly

The Annual Otolaryngologic Assembly of 1968 will be held October 12–18, in the Illinois Eye and Ear Infirmary at the Medical Center, Chicago. The Department of Otolaryngology of the College of Medicine of the University of Illinois offers a condensed postgraduate basic and clinical program for practicing otolaryngologists under the direction of Doctor Emanuel M. Skolnik. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

A separate, but correlated course entitled "Head and Neck Radiology Conference," under the guidance of Doctor Galdino E. Valvassori, will be conducted by the Department of Radiology for two full days just preceding the Assembly, Thursday and Friday, October 10 and 11.

Interested physicians should direct communications to the mailing address: Department of Otolaryngology, P. O. Box 6998, Chicago, Ill. 60680.

Clinical Electroencephalography

A continuation course in Clinical Electroencephalography will be held September 9–11 in San Francisco, Calif. The course is designed as a basic review of the applications of the EEG to clinical medical practice, and is sponsored by the American EEG Society (aided by a grant from the National Center for Chronic Disease Control, U. S. Public Health Service).

The faculty will include Drs. Reginald G. Bickford, Rochester, Minn.; David D. Daly, Dallas, Tex.; Robert J. Ellingson, Omaha, Neb.; Eli S. Goldensohn, New York, N. Y.; Charles E. Henry, Cleveland, Ohio; Peter Kellaway, Houston, Tex.; John R. Knott, Iowa City, Iowa; Michael G. Saunders, Winnipeg, Canada; Daniel Silverman, Philadelphia, Pa.; Richard D. Walter, Los Angeles, Calif.

Inquiries about further details of the course or registration procedure should be addressed to Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, Rochester, Minn. 55901.

SMS Members Invited to Wisconsin Dental Meeting

All members of the State Medical Society of Wisconsin are invited to attend the 98th Annual Session of the Wisconsin State Dental Society at the Milwaukee Auditorium, April 22–24. A number of fine scientific programs of mutual interest to both professions will be presented all three days. Your current membership card is all that is required to register. Registration will be conducted in the inner corridor of the Auditorium, to the left of the Kilbourn Avenue entrance.

TENTATIVE SCIENTIFIC PROGRAM

STATE MEDICAL SOCIETY OF WISCONSIN

1968 Annual Meeting • May 14–16

Milwaukee Auditorium and Hotel Schroeder

TUESDAY, MAY 14: MORNING SESSION

Osteoporosis

1. **THE EFFECT OF AGE AND POSTMENOPAUSAL OSTEOPOROSIS ON THE INTESTINAL ABSORPTION OF CALCIUM**
   Louis V. Avioli, MD, St. Louis, Mo.
2. **FACTORS INVOLVED IN THE DEVELOPMENT OF OSTEOPOROSIS**
   Robert P. Heaney, MD, Omaha, Neb.
3. **PANEL DISCUSSION**
   Doctors Avioli and Heaney.

TUESDAY, MAY 14: NOON LUNCHEONS

1. **THE DIFFERENTIAL DIAGNOSIS OF HYPERCALCEMIA**
   Louis V. Avioli, MD, St. Louis, Mo.
2. **DIAGNOSIS AND TREATMENT OF METABOLIC BONE DISEASE**
   Robert P. Heaney, MD, Omaha, Neb.
3. **PHILOSOPHY OF RESPIRATORY CARE**
   Thomas Lee Petty, MD, Denver, Colo.
4. **MANAGEMENT OF THE PATIENT WITH SARCOIDOSIS**
   Benjamin Burrows, MD, Chicago, Ill.
5. **SELECTIVE ANGIOGRAPHY IN THE HEAD AND NECK**
   William N. Hanafee, MD, Los Angeles, Calif.
6. **ASEPTIC NECROSIS OF BONE**
   William Martel, MD, Ann Arbor, Mich.
7. **CHROMOSOMAL ASPECTS OF PREGNANCY WASTAGE**
   David Yi-Yung Hsia, MD, Chicago, Ill.
8. **URETHRAL SUSPENSION**
   Richard F. Mattingly, MD, Milwaukee
9. **CLOMID—ONE YEAR LATER**
   Gloria E. Sarto, MD, Madison

TUESDAY, MAY 14: AFTERNOON SESSION

Medicine

Moderotor: EDWARD K. RYDER, JR., MD, Madison

Three progroms running concurrently: Medicine, Obstetrics–Gynecology, and Radiology

1. **THE NATURAL HISTORY AND PROGNOSIS OF OBSTRUCTIVE EMPHYSEMA**
   Benjamin Burrows, MD, Chicago, Ill.
2. **PULMONARY REHABILITATION**
   Thomas Lee Petty, MD, Denver, Colo.
3. **PANEL DISCUSSION; QUESTIONS AND ANSWERS**
   Doctors Burrows, Petty, Helen A. Dickie and John Rankin, Madison

Obstetrics & Gynecology

Moderator: Joseph C. Fralich, MD, Rocine

1. **GAMMA GLOBULIN IN THE PREVENTION OF RH. ISO-IMMUNIZATION**
   Serafeim P. Masouredis, MD, Milwaukee
2. **GENETIC FACTORS IN PREGNANCY WASTAGE**
   David Yi-Yung Hsia, MD, Chicago, Ill.
3. **OUR RESPONSIBILITY IN THE DEFINITION OF PATTERNS IN MATERNAL AND NEWBORN CARE**
   Ben M. Peckham, MD, Madison
4. **PANEL DISCUSSION**
   Doctors Masouredis, Hsia, and Peckham

Radiology

Moderator: ANDREW B. CRUMMY, JR., MD, Madison

1. **SELECTIVE ANGIOGRAPHY IN THE HEAD AND NECK**
   William N. Hanafee, MD, Los Angeles, Calif.
2. **THE SPONDYLITIS OF RHEUMATOID ARTHRITIS**
   William Martel, MD, Ann Arbor, Mich.
3. **PANEL DISCUSSION**
   Doctors Hanafee and Martel

TUESDAY, MAY 14: EVENING EVENTS

1. **RADIOLOGY DINNER**
   Speaker: William Martel, MD, Ann Arbor, Mich.
   TOPIC: PRACTICAL POINTS IN THE DIAGNOSIS OF JOINT DISEASES
2. **UNIVERSITY OF WISCONSIN MEDICAL ALUMNI ASSOCIATION DINNER**
3. **MARQUETTE MEDICAL ALUMNI ASSOCIATION DINNER**

WED., MAY 15: MORNING SESSION

General

1. **USE OF COMPUTERS IN MEDICINE**
   Moderator: C. DANIEL GEISLER, SCD, Madison
   Participants: G. Phillip Hicks, PhD, Madison
   Vincent C. Rideout, MS, Madison
   Warner V. Slack, MD, Madison
2. **PROMISING NEW DEVICES FOR USE IN MEDICINE**
   Moderator: JOHN G. WEBSTER, PhD, Madison
   Participants: Edwin N. Lightfoot, PhD, Madison
   John W. Mitchell, PhD, Madison
   Stuart J. Updike, MD, Madison

WED., MAY 15: NOON LUNCHEONS

Eight programs running concurrently

1. **ALLERGIC DERMATOLOGIC MANIFESTATIONS OF ARTHROPOD EXPOSURE**
   Frank Perlman, MD, Portland, Ore.
2. **TREATMENT OF COMMON SKIN DISEASES**
   Arthur C. Curtis, MD, Ann Arbor, Mich.
3. **TITLE PENDING**
   J. Preston Robb, MD, Montreal, Canada
4. **IMMUNIZATIONS: PAST, PRESENT AND FUTURE**
   Vincent A. Fulginiti, MD, Denver, Colo.
5. **VASCULAR PROBLEMS ASSOCIATED WITH PREGNANCY**
   Richard D. Sautter, MD, Marshfield
6. **TITLE PENDING**
   William S. Middleton, MD, Madison
7. **BIOMEDICAL ENGINEERING RESEARCH**
   C. Daniel Geisler, ScD, Madison
8. **BIOMEDICAL INSTRUMENTATION**
   John G. Webster, PhD, Madison

WED., MAY 15: AFTERNOON SESSION

Four programs running concurrently: Allergy, Dermatology, Neurology, Pediatrics

Allergy

Moderator: DAVID M. GLASSNER, MD, Milwaukee

1. **EFFECTS OF NEBULIZED MEDICATION IN TREATMENT OF ASTHMA AND CHRONIC BRONCHOPULMONARY DISEASES**
   Frank Perlman, MD, Portland, Ore.

ABBREVIATED TIMETABLE

(Subject to Change)

Annual Meeting—State Medical Society

MAY 11–16, 1968—MILWAUKEE

pm	**SATURDAY, MAY 11**
5:30	Executive Committee—Council
pm	**SUNDAY, MAY 12**
12:00	Council Luncheon
2:00	Council Meeting
6:00	50-Year Club Dinner
pm	**MONDAY, MAY 13**
1:00	Congress of Delegates—Wisconsin Academy of General Practice
7:00	First Session—House of Delegates
am	**TUESDAY, MAY 14**
7:30	Breakfast—Professional Association for Civic Education (PACE)
8:00	Registration and opening of exhibits
9:00	Reference Committees
9:30	Scientific Program: "Osteoporosis"
pm	
12:00	Clinic Managers' Luncheon
12:30	Scientific Luncheons (9)
2:00	Scientific Programs in Medicine, Obstetrics–Gynecology, and Radiology
6:00	Buffet Supper—House of Delegates
6:00	Alumni Dinners—University of Wisconsin and Marquette
6:00	Radiology Dinner
7:30	Second Session—House of Delegates
am	**WEDNESDAY, MAY 15**
9:00	Third Session—House of Delegates
9:30	Scientific Programs in "Use of Computers in Medicine"
11:00	Council Meeting
pm	
12:30	Council Luncheon
12:30	Scientific Luncheons (8)
2:00	Scientific Programs in Dermatology, Neurology, Pediatrics, and Allergy
6:30	President's Reception
7:15	Annual Dinner
am	**THURSDAY, MAY 16**
8:00	Clinic—Wisconsin Surgical Society at Wood VA Center
9:30	Scientific Programs in Ear–Nose–Throat and Ophthalmology
10:00	Resident-Intern Program
pm	
12:30	Scientific Luncheons (8)
2:00	Scientific Programs in Anesthesia, Ophthalmology, and Surgery
2:00	SMS Section on Ear, Nose and Throat Business Meeting and Wisconsin Otolaryngology Society
7:00	Wisconsin Surgical Society Dinner

2. **CASE PRESENTATIONS: DIRE EFFECTS OF ABUSIVE SELF-ADMINISTERED NEBULIZED MEDICATION**
   David M. Glassner, MD, Milwaukee

3. **ROUNDTABLE DISCUSSION: THE USE AND ABUSE OF NEBULIZED MEDICATION**
   Frank Perlman, MD, Portland, Ore.
   Richard P. Jahn, MD, Milwaukee
   David M. Glassner, MD, Milwaukee

4. **RECENT ASPECTS OF PIGEON BREEDER'S DISEASE**
   Abe Sosman, MD, Milwaukee

Dermatology

Moderator: JAMES W. BRINGE, MD, Sheboygan

1. **COLLAGEN DISEASE AS SEEN BY THE DERMATOLOGIST**
   Arthur C. Curtis, MD, Ann Arbor, Mich.

2. **SKIN DISEASES AGGRAVATED BY SUNLIGHT**
   Derek J. Cripps, MD, Madison

3. **PANEL DISCUSSION**
   Arthur C. Curtis, MD, Ann Arbor, Mich.
   Derek J. Cripps, MD, Madison

Neurology

Moderator: FRANCIS M. FORSTER, MD, Madison

1. **CLINICAL DIAGNOSIS OF EPILEPSY**
   J. Preston Robb, MD, CM, Montreal, Canada

2. **ROLE OF ELECTROENCEPHALOGRAPHY IN THE DIAGNOSIS OF EPILEPSY**
   Francis M. Kruse, MD, Marshfield

3. **NEUROPSYCHOLOGICAL EVALUATION OF THE EPILEPTIC PATIENT**
   Charles G. Matthews, MD, Madison
   Hallgrim Klove, PhD, Madison

4. **MEDICAL MANAGEMENT OF EPILEPSY**
   Philip T. White, MD, Milwaukee

5. **SURGICAL MANAGEMENT OF THE EPILEPTIC**
   Flavio Puletti, MD, Madison

6. **CONDITIONING IN CERTAIN CASES OF EPILEPSY**
   Francis M. Forster, MD, Madison

7. **THE PHYSICIANS' ROLE IN HANDLING THE SOCIAL IMPLICATIONS OF EPILEPSY**
   Jean P. Davis, MD, Milwaukee

Pediatrics

Moderator: WILLIAM H. BARTLETT, MD, Madison

1. **THE INVESTIGATION AND TREATMENT OF GROWTH DISORDERS IN CHILDREN**
   George R. Kerr, MD, Madison

2. **QUESTION AND ANSWER PERIOD**

3. **PEPTIC ULCER IN CHILDREN, A FAMILIAL DISEASE**
   Frederic M. Blodgett, MD, Milwaukee

4. **QUESTION AND ANSWER PERIOD**

5. **A NEW LOOK AT IMMUNOLOGIC DEFICIENCY DISEASES**
   Vincent A. Fulginiti, MD, Denver, Colo.

6. **PANEL DISCUSSION**

THURSDAY, MAY 16: MORNING SESSION

General

Three programs running concurrently

1. **RESIDENT–INTERN PAPERS**
   Chairman: THOMAS V. GEPPERT, MD, Madison

2. **SECTION ON OPHTHALMOLOGY: CLINIC ON APPLANATION TONOMETRY**
   Chairman: JAMES V. BOLGER, MD, Milwaukee
   Luncheon and business meeting at noon

3. **WISCONSIN SURGICAL SOCIETY**
   Chairman: BEN R. LAWTON, MD, Marshfield

4. **SEMINAR ON THE KIDNEY (all day)**
   Special In-depth Teaching Program covering physiology, pathology, and diseases of clinical interest. (LIMITED TO 30 PHYSICIANS)

Ear–Nose–Throat

Moderator: JOHN K. SCOTT, MD, Madison

1. **AN OTOLARYNGOLOGIST'S APPROACH TO FACIAL FRACTURES**
   Willis G. McMillan, MD, Madison

2. **A SURGICAL APPROACH TO DEAFNESS**
   Michael Paparella, MD, Minneapolis, Minn.

3. **A GROUP APPROACH TO HEARING AND SPEECH PROBLEMS IN CHILDREN**
   Michael Paparella, MD, Minneapolis, Minn.
   Stanley Ewanowski, PhD, Madison
   Charles Tait, PhD, Madison

THURSDAY, MAY 16: NOON LUNCHEONS

Six programs running concurrently

1. **TITLE PENDING (Surgical)**
   John S. Najarian, MD, Minneapolis, Minn.

2. **THE PACEMAKER PATIENT: WILL THE CAUTERY TURN HIM OFF?**
   John M. R. Bruner, MD, Groton, Mass.

3. **THE OTOLOGIST'S APPROACH TO THE SUSPECTED DEAF PRE-SCHOOL CHILD**
   Michael Paparella, MD, Minneapolis, Minn.
4. **ENGINEERING IN MEDICINE AND BIOLOGY**
   Anthony Sances, PhD, Milwaukee
5. **NEWER DRUGS AND THEIR USES**
   Ovid O. Meyer, MD, Madison
6. **HEADACHES**
   J. D. Kabler, MD, Madison
7. **NEW DRUGS AND THE TREATMENT OF VIRUS INFECTIONS**
   June E. Osborn, MD, Madison
8. **JOINT MEETING: SECTIONS ON OPHTHALMOLOGY AND EAR–NOSE–THROAT**
   (No Speaker)

THURS., MAY 16: AFTERNOON SESSION

Three programs running concurrently

Anesthesiology

Moderator: FREDERICK D. COOK, MD, Green Bay

1. **ELECTRICAL HAZARDS IN HOSPITALS**
   John M. R. Bruner, MD, Groton, Mass.
2. **PRESENT STATUS OF ELECTRO-ANESTHESIA**
   Anthony Sances, PhD, Milwaukee
3. **PANEL DISCUSSION or BUSINESS MEETING OF SECTION**

Ophthalmology

Moderator: JAMES V. BOLGER, MD, Milwaukee

1. **RECENT ADVANCES IN SERONEGATIVE OCULAR SYPHILIS**
   J. Lawton Smith, MD, Coral Gables, Fla.
2. **PRESENTATION OF PAPERS FROM WISCONSIN PHYSICIANS**
3. **CLINICOPATHOLOGIC CONFERENCE**

Surgery

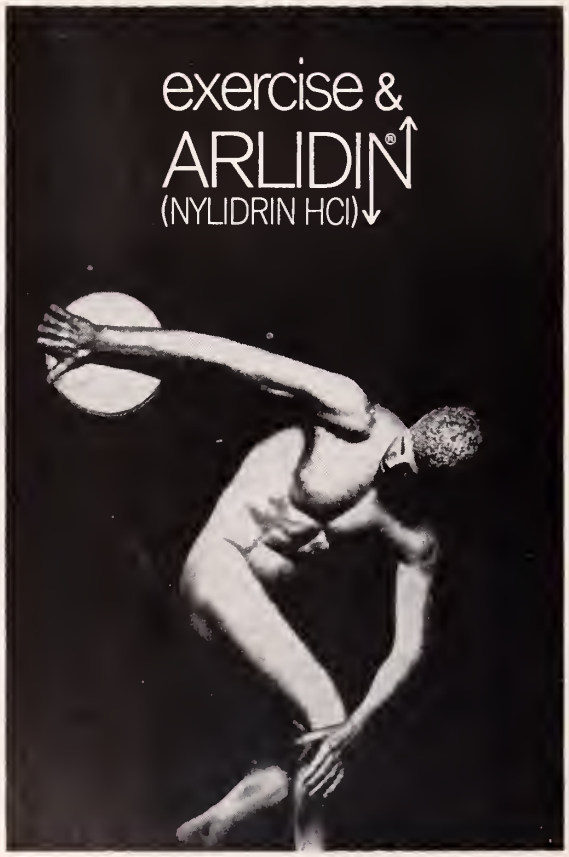
Moderator: BEN R. LAWTON, MD, Marshfield

1. **TITLE PENDING**
   John S. Najarian, MD, Minneapolis, Minn.

(Balance of program is pending)

Seminar on the Kidney

Continued from the morning session.



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SMS Cites State's 4-H Clubs for Health Education Programs

Again for 1967 the State Medical Society has honored a group of the state's 4-H clubs cited by their leaders for outstanding health education programs.

Each of 43 clubs has been presented a one-year subscription to TODAY'S HEALTH with Society compliments. In addition the leader of each club receives a pass, for her and her family, to the Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien.

Selection of the winners is made from the state's 2,300 4-H clubs by the Department of 4-H and Youth of the University of Wisconsin Extension.

Health Achievement Awards are sent to the winning groups, over the signatures of the State Medical Society president and the president of the local county medical society.

The awards are an annual event with the State Medical Society. Agnes M. Hansen, assistant state 4-H leader, writes that she is "sure that the practice has helped maintain (club) interest in the health activity when I note the many repetitions of names from year to year, indicating the excellent work they have done."

* * *

MEDICAL INSURANCE **premiums are more fully deductible on returns due this year.** A recent law change enables taxpayers who itemize income-tax returns to deduct half of their medical-insurance outlays to a maximum of $150 for the year starting Jan. 1, 1967. The remainder may be added to a taxpayer's other health-care costs; such other expenses, however, are deductible only to the extent they exceed 3% of taxable income. Prior to the 1967 tax year, insurance costs could only be added to other medical bills to build the 3% "floor." Many taxpayers thus weren't able to claim deductions because their health expenses didn't top that limitation.—THE WALL STREET JOURNAL, Jan. 10, 1968

* * *

AN APPRAISAL FEE **paid to determine the value of property donated to a charitable organization is a deductible expense,** the IRS ruled. Such fees are a legitimate expense in determining tax liability and thus can be claimed in full in figuring taxable income, the Service held. The fees, it stressed, don't have to be included in the charitable deduction itself, which is subject to limitations.—THE WALL STREET JOURNAL, Jan. 10, 1968

* * *

CLAIMS FOR Medicare's medical insurance for services furnished in July, August, or September 1966 must be filed by Mar. 31, 1968.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY HOME DURING THE MONTH OF JANUARY 1968

2 Board of Trustees, Dane County Medical Society

4 Editorial Subcommittee, SMS Division on School Health of Commission on State Departments

9 Inter-Hospital Coordinating Disaster Committee

10 Wiseonsin State Health Council (Madison)

15 Insurance Advisory Committee, Dane County Medical Society

16 Planning Committee, Dane County Medical Society

16 Public Hearing, Wisconsin Division of Health of Department of Health and Social Services (Milwaukee)

17 SMS Division on Handicapped Children of Commission on State Departments

17 Nominating Committee, Wisconsin Association of Professions

17 Editorial Committee, SMS Section on Ophthalmology

18 SMS Division on School Health of Commission on State Departments

18 Subcommittee, SMS Division on School Health of Commission on State Departments

18 University of Wisconsin "In-depth" Scientific Program

18 Public Hearing, Wisconsin Division of Health of Department of Health and Social Services (Eau Claire)

19 Madison Press Club

20 Executive Committee, SMS Council

20 Executive Committee, SMS Commission on Medical Care Plans

20 Planning Committee, SMS Council

20 Executive Committee, SMS Commission on Hospital Relations and Medical Education

20 Cancer Study Committee, Wisconsin Regional Medical Program

21 Wisconsin Chapter, National Multiple Sclerosis Society

23 Madison Radiology Study Group

24 Executive Committee, SMS Section on Ophthalmology

24 Legislative Committee, SMS Section on Ophthalmology

24 Educational Committee, SMS Section on Ophthalmology

25 Executive Committee, SMS Charitable, Educational and Scientific Foundation

26 SMS Ad Hoc Committee on The Medical Practice Act

Meetings not held in the Society Home but which have a direct relationship are printed in italics, with the location in parentheses.

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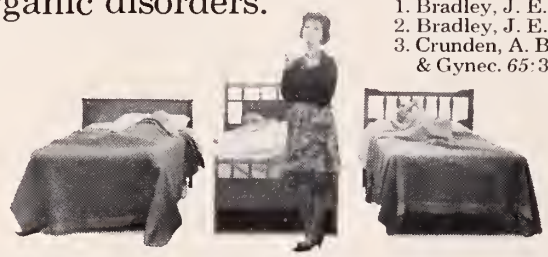
1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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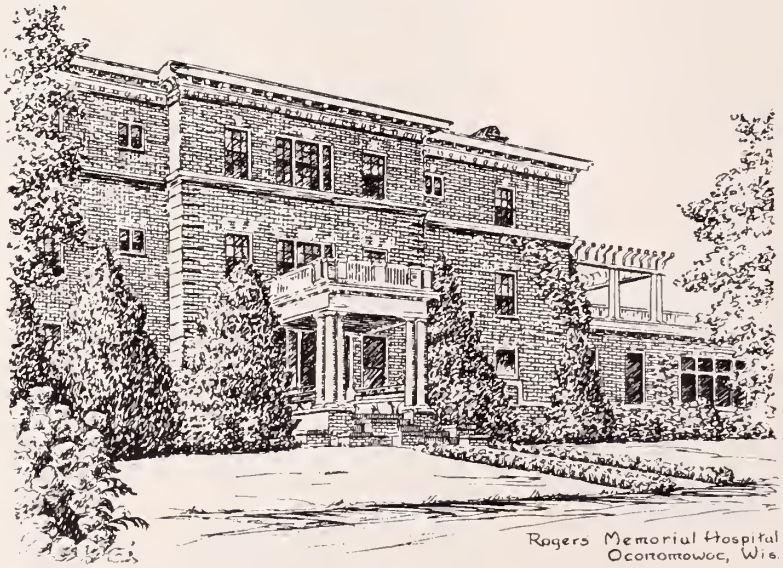

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director
EUGENE B. FRANK, M. D.
LOREN J. DRISCOLL, M. D.
THOMAS J. GORAL, M. D.
JOHN J. O'HARA, M. D.
EARL F. WEIR, M. D.
LEROY WAUCK, Ph. D.
Clinical Psychologist
ROBERT TESTIN, Ph. D.
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NEWS OF WISCONSIN PHYSICIANS

St. Joseph's Medical Staff Elects

New officers of the medical staff of St. Joseph's Hospital, Superior, were recently elected as follows: *Drs. Robert Mann*, chief-of-staff, *Roger Thompson*, chief-of-staff for 1969 and *Enzo Krahl*, secretary.

Dr. Curreri Heads UW Surgery Dept.

Dr. Anthony R. Curreri was appointed Jan. 16 chairman of the surgery department at the University of Wisconsin Medical School. The appointment was recommended by *Dean Peter L. Eichman* and confirmed by Chancellor William Sewell.

Doctor Curreri succeeds *Dr. Robert C. Hickey*, who has been named deputy director of the University of Texas M.D. Anderson Hospital and Tumor Institute, Houston. Before his appointment as surgery chairman in 1963, Doctor Hickey was associate director of research at the Anderson Hospital. Over the next few months he will be in the process of making the transition.

Dr. A. R. Curreri

The new chairman was recommended for the position by an eight-member search committee appointed by Doctor Eichman last summer after Doctor Hickey announced that he would not continue as chairman for an extended period of time.

A professor of surgery and clinical oncology, Doctor Curreri served as director of the Medical School division of clinical oncology since its creation in 1963, and has been on the Wisconsin faculty since 1939.

The search committee, headed by *Dr. John H. Juhl*, professor and chairman of radiology, conducted its search both nationally and within the Medical School in order to find the strongest possible candidate, Doctor Eichman said.

Doctor Curreri has three degrees from Wisconsin: the bachelor's degree, 1930; the master's, 1931; and the M.D., 1933. Following his graduation from Medical School, he interned at Columbia Hospital and Children's Hospital, Milwaukee, from 1933 to 1935.

Doctor Curreri's first post as a physician was on Isle Royal, Mich., where because of complete isolation seven months of the year, he was forced to practice without the advantages of the many ancillary services ordinarily available to physicians. He returned to Wisconsin in 1936 for a three-year residency at the University Hospitals and was appointed instructor of surgery in 1939. He became full professor in 1954.

He was appointed director of the cancer research division of the department of surgery and held that position until the division of clinical oncology was created in 1963. He was appointed director of the division.

His research interests early in his career were related to peritonitis, and later they were centered about the newly developed specialty of thoracic surgery. Now his research interests center in thoracic surgery and clinical oncology.

In 1948 he also became a member of the medical and executive committees of the American Cancer Society, Wisconsin Division. At various times, he acted as its president and chairman of the board of trustees.

In addition, he has been a member of the national board of directors of the American Cancer Society, which awarded him in 1958 its bronze medal for distinguished service to cancer control.

At the request of the surgeon general of the Army, Doctor Curreri went to the Korean war front in 1952 to study the use of Dextran as a substitute for plasma in preventing the shock observed in the war wounded. Most hospitals now use Dextran in serious emergencies.

Doctor Curreri is surgical consultant to the surgeon general of the Army and served on the Public Health Service's National Advisory Cancer Council.

He has served in many other consultative positions, and in addition has membership in numerous scientific and medical societies and accreditation boards. He has published 60 papers.

Dr. Hoon Explains Gastro Camera

A Sheboygan physician, *Dr. James R. Hoon*, late last year, reported on his work in the study and treatment of diseases of digestive organs at the Sheboygan Clinic to members of the American College of Gastroenterology meeting in Los Angeles. Doctor Hoon displayed and explained the workings of a camera that snaps color photos of the inside of the stomach to spot cancers and ulcers that x-ray analysis often misses. He said that of 600 patients he has photographed, 18 were found to have stomach cancer. And of the 18, seven cancers did not show up on x-ray films.

The Late Dr. Kay Aids Medical Library

The University of Wisconsin Regents have accepted a bequest of the late Dr. Harry M. Kay, well known Madison physician who died June 3, 1966, in which half of the residue of his estate, upon termination of a life trust for members of his family and relatives, is to be "for the use and benefit of the William S. Middleton Library" in the UW Medical Center. The amount of the bequest is still undetermined.

Physicians whose names appear in italics are members of the State Medical Society.

DR. JOHN KNAUF, right, was presented the Stockbridge Chamber of Commerce's award as the outstanding citizen by Emil Kufahl at the Chamber's annual meeting in December. (Thiel Photo from Appleton Post—Crescent)

Dr. John Knauf Honored

Thirty-two years of dedicated service to the Stockbridge area's health needs earned *Dr. John Knauf* recognition in December as Stockbridge's outstanding citizen. He was the first to receive the award given by the Chamber of Commerce which plans to give one annually.

Doctor Knauf was born in Chilton. He received his medical degree from Marquette University in 1935. He started his practice at his present location, and at that time he held the distinction of being the youngest doctor practicing in Wisconsin. He was 23 years old.

Doctor Knauf comes from a family of doctors. He has been instrumental in the development of his community, including organization of the Stockbridge Chamber of Commerce and promotion of skiing in the area. He was Calumet County coroner for 17 years.

Dr. Garner Guest Speaker

Dr. Lawrence L. Garner, Wood, recently was the guest speaker before the Brooklyn Ophthalmological Society in Brooklyn, New York. The subject he presented was "Difficulties in the Diagnosis of Glaucoma."

Dr. Vitulli Certified

Dr. V. N. Vitulli, Cudahy, recently was certified by the American Board of Obstetrics and Gynecology.

Dr. Primakow Retires

Dr. Max Primakow, Wood, chief of the psychiatry and neurology department at the Veterans Administration Hospital, recently retired. He also retired from the psychiatry and neurology department of the Marquette School of Medicine where he was an associate professor. Doctor Primakow began his work at Wood in 1939 after working with the VA at Sawtelle, Calif. He is a graduate of the Marquette School of Medicine.

Dr. Armagan Appointed to Staff

Dr. Senekerim Armagan, Chicago, recently was appointed to the staff of Trinity Memorial Hospital in Cudahy. Doctor Armagan graduated from the University of Istanbul and interned at St. Bernard's Hospital and Wesley Memorial Hospital in Chicago. He was an instructor in Otolaryngology at Northwestern university before joining Trinity Memorial Hospital.

Dr. Campbell Returns Home

Dr. Paul E. Campbell, Waukesha, recently resumed his practice after serving on the hospital ship SS HOPE which was docked at Cartagena, Colombia, South America. Doctor Campbell, who is on the staff at Waukesha and Oconomowoc Memorial hospitals, often dealt with ailments in Colombia not often encountered in American practice.

Dr. Schultz Opens Office

Dr. William F. Schultz, Kiel, recently opened an office in Two Rivers. Doctor Schultz graduated

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from the University of Tennessee Medical School and interned at St. Joseph Hospital, Memphis, Tenn. He served for several years in the Cadet Air Force before beginning practice in Kiel in 1962.

Marshfield Clinic Holds Seminar

Dr. James S. Vedder, Marshfield, recently was the first guest speaker at the Marshfield Clinic Foundation's 1967–68 seminar program. The guests included students and faculty members of Marshfield Senior High School and Columbus High School. Doctor Vedder, introduced by *Dr. R. F. Lewis*, president of the Clinic, related his experiences with the hospital ship HOPE in Colombia, South America.

Dr. Tolentino Locates in Adell

Dr. Jose Q. Tolentino, of The Philippines, will begin his practice of medicine in Adell the first of March. Doctor Tolentino, who is completing his residency at Deaconess Hospital in Milwaukee, volunteered for the Adell position last April in response to national publicity of the Adell situation. Doctor Tolentino graduated from Far Eastern University, Manila, and interned at two other Milwaukee hospitals, Mount Sinai and St. Michael's. The village has been without a physician since 1965.

Dr. Albright Lectures in Duluth

Dr. Edwin C. Albright, professor of medicine, UW Medical Center, Madison, recently spoke at a medical staff meeting of St. Luke's Hospital, Duluth, Minn. His subject was the "Diagnosis and Treatment of Adult Hypothyroidism."

Dr. Najafzadeh Opens Private Practice

Dr. Moktar Najafzadeh, who is medical director of Camp McCoy Job Corps, has opened a private office for general medicine and surgery in Sparta. He came to the United States in 1960 and was the admitting physician at Coney Island General Hospital, New York, before coming to Wisconsin in November 1966 to become the Job Corps medical director. Of Russian descent, he studied medicine at Lyon, France. Following internship in France and Turkey, he practiced in Iran for 23 years.

Dr. Sattler, Kenosha, Honored

Dr. Chester A. Sattler of Kenosha has been certified and elected to life membership in the Orthopaedic Research and Education Foundation sponsored by the American Academy of Orthopaedic Surgeons. He was selected by the trustees of the foundation for his significant support to the organization. Doctor Sattler has been practicing orthopedic surgery in the Kenosha area since 1950.

Doctors Welcomed at Neillsville

Dr. and Mrs. Nazario Capati, natives of The Philippines, were welcomed by the entire medical fraternity of Neillsville at a banquet held at Memorial Home. The couple recently arrived here from Winnipeg, Canada.

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*anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic?)

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PHYSICIAN NEWS *continued*

Dr. Curtis Named to Paine Board

Dr. and Mrs. *John K. Curtis* of Madison have been named trustees to serve on the Members' Board of the Paine Art Center and Arboretum in Oshkosh. Doctor Curtis is chief of medicine at the Veterans Administration Hospital, Madison, and on the staff at the University of Wisconsin Hospitals. His mother, the late Mrs. Clinton J. Curtis, was a sister of Mrs. Nathan Paine, co-founder of the Paine Art Center and Arboretum.

Dr. Riabov Joins Superior Clinic

Dr. S. N. Riabov is now associated with the Superior Clinic, specializing in pediatrics. His medical degree was received from the University of Strausbourg, France, in 1956. He served his internship and residency in Cincinnati, Ohio, from 1957 to 1960. Following his residency in pediatrics, Doctor Riabov served as research fellow in the Genetics–Biochemistry Laboratory of Children's Memorial Hospital in Chicago.

During the past two years he has been associated with Wisconsin Central Colony in Madison as a biochemist. He was certified as a diplomate of the American Board of Pediatrics in 1964.

Dr. Middleton Guest Speaker

Dr. William S. Middleton, Madison, dean emeritus of the University of Wisconsin Medical School and consultant in residence for research and education at the Veterans Administration Hospital, recently delivered the keynote address of the 74th annual meeting of the Association of Military Surgeons of the United States in Washington, D.C.

Dr. Hofmeister Honored

Dr. Frederick J. Hofmeister, Milwaukee, chairman of the Gynecology and Obstetrics department at Lutheran Hospital, recently was given the award as "Lutheran Man of the Year." Doctor Hofmeister, who has also written many papers on gynecology and obstetrics and has produced eight teaching films, is the first physician to be honored by the Lutheran Men in America which has singled out a prominent church layman annually since 1959.

Physicians Elected to Board

Drs. Richard K. Chambers, Hartland Clinic, *John L. Claude,* Wilkinson Clinic, and *G. Daniel Miller,* chief of anesthesia at Memorial Hospital in Oconomowoc, recently were elected to corporate membership on the board of directors at Memorial Hospital in Oconomowoc.

Dr. J. D. Van Liere Named Chief-of-Staff

Dr. J. D. Van Liere, Burlington, recently was elected chief-of-staff at the Memorial Hospital. Also elected were *Dr. Paul Gander* as vice-chief-of-staff and *Dr. Robert Batsleer* as secretary–treasurer.

Dr. Lipman Speaks in Canada

Dr. William H. Lipman, Kenosha, recently addressed the International Congress of Allergology meeting in Montreal, Canada. His topic was "The Treatment of Broncho-pulmonary Obstructive Disease States."

Dr. Malley Guest Speaker

Dr. Michael Malley, Hartford, recently spoke on "Heart Disease and Its Implications on Industrial Potential," at the meeting of the Manitowoc Safety Council at Cape Cod Inn. Doctor Malley is chief of the cardiac classification unit of the Curative Workshop, Milwaukee.

Pediatricians Elected to Academy

Drs. John M. Opitz, June E. Osborn, Madison, and Phillip M. Forman, Middleton, Walter Schroeder, Beloit, and *Clifton R. Peterson*, Fond du Lac, were recently elected to fellowships in the American Academy of Pediatrics.

Dr. Schmitt Joins Clinic

Dr. Albert Schmitt, Waukegan, Ill., recently became associated with the Adams County Memorial Hospital and the Roche-a-Cri Clinic. Doctor Schmitt is a graduate of the Marquette University School of Medicine and practiced for six years in Waukegan before joining the Clinic.

Dr. Giffin Guest Speaker

Dr. Walter Giffin, Appleton, recently gave his views on sex instructions for children in Chilton. The lecture was one of a series being sponsored by the Calumet County Adult Catholic Education Program.

Dr. Shearer Guest Speaker

Dr. Tom Shearer, Edgerton, recently was the guest speaker at a Rotary meeting in Edgerton. Doctor Shearer outlined the use of mouth-to-mouth resuscitation and cardiac massage in treating persons who have suffered heart attacks or electrical shock.

DR. HELEN A. DICKIE

Dr. Dickie Discusses Tuberculosis

Late last fall *Dr. Helen A. Dickie* opened Wisconsin's 1967 Christmas Seal campaign by remarking, "When I make hospital rounds, I'm reminded each day of the suffering and grief caused by tuberculosis." As president of the Wisconsin Anti-Tuberculosis Association and chairman of the campaign, Doctor Dickie emphasized the WATA's testing program and its other activities which are supported by the Christmas Seal fund.

Doctor Dickie, who is professor of medicine in the University of Wisconsin Medical School, has devoted her professional life to the study of respiratory diseases, and has made substantial contributions to the understanding of some of these diseases.

Dr. Hildebrand Guest Speaker

Dr. Fredric Hildebrand, Menasha, recently spoke on "Heart Attacks" before the Twin City Safety Council meeting held in Germania Hall, Menasha.

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Dr. Schultz Returns from Vietnam

Dr. I. H. Schultz, retired Mazomanie general practitioner, returned in January from a two-month stay in Vietnam where he served the civilian population through the American Medical Association Volunteer Physicians for Vietnam. Although Doctor Schultz is 69 years old, he is in excellent physical condition which allowed federal officials to waive the regular 55 maximum age limit for doctors working in Vietnam.

Dr. I. H. Schultz

Stating his reasons for volunteering, Doctor Schultz said: "The civilian people of Vietnam are greatly in need of medical care. I have retired from active practice, and have no immediate members of a family to think about. This gives me an opportunity to enrich the purpose of my life—namely, to prolong life and to minimize physical pain and mental anguish."

Doctor Schultz came to America from Russia when he was 15 years old and took up residence with an aunt and uncle in Madison. He attended Madison schools, graduated from the University of Wisconsin Medical School, and interned for two years at Madison's St. Mary's Hospital after which he set up his practice in Mazomanie. He has returned to Mazomanie where he is revered as an individual and civic leader as well as a doctor. (Photo courtesy THE CAPITAL TIMES)

Dr. Devine Wins Honors

Dr. Joseph C. Devine, Fond du Lac, recently was initiated into membership in the American College of Surgeons in Chicago. Doctor Devine is a diplomate of the American Board of Surgery.

Dr. Mudge Guest Speaker

Dr. William A. Mudge, Jr., Kenosha, recently spoke on arthritis care, the varieties of the disease, and general treatment, before the Homemaker's Club in Kenosha. The film, "The Afflicted," was also shown.

Dr. Dietsche Opens Practice

Dr. Wolfgang O. W. Dietsche, Wisconsin Rapids, recently opened offices in Wisconsin Rapids. Doctor Dietsche is a graduate of the University of Freiburg in Germany and had been associated with the Carle Clinic in Urbana, Ill. for seven years before coming to Wisconsin Rapids. Prior to his practice in Illinois, Doctor Dietsche served a rotating internship at New Rochelle (New York) Hospital and orthopedic residency at Mount Carmel Hospital and Children's Hospital in Ohio. He was also an instructor in orthopedics in the College of Medicine, Ohio State Uni-

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versity. Doctor Dietsche is a diplomate of the American Board of Orthopedic Surgery, a fellow of the American College of Surgeons, and has been elected to a fellowship in the American Academy of Orthopedic Surgeons.

Dr. Pavlic Elected President

Dr. Robert S. Pavlic, Brookfield, recently was elected president of the Advisory Board of the Milwaukee Archdiocesan Catholic Family Life Program. Doctor Pavlic will serve a two-year term.

Dr. Houfek Guest Speaker

Dr. Edward E. Houfek, Sheboygan, medical director of the County Guidance Center, recently spoke on his experiences on the West Indian Leeward Island of St. Kitts and Nevis before the Memorial Hospital Auxiliary. Doctor Houfek, accompanied by his wife and six children, spent five weeks on these islands on a volunteer service basis. He was the fourth psychiatrist from the United States to participate in the mental health program which is sponsored by the United States Caribbean Aid to Mental Health, Inc.

Dr. Rice Speaks at Seminar

Dr. Raymond L. Rice, Milwaukee, past president of the Wisconsin Heart Association, presented the story of Wisconsin's efforts in establishing guidelines for workmen's compensation in cardiac cases, at the "Heart in Industry's" seminar held Nov. 9–10 in Boston. The seminar was sponsored by the Massachusetts Heart Association and the Tufts University School of Medicine.

Dr. Theiler Guest Speaker

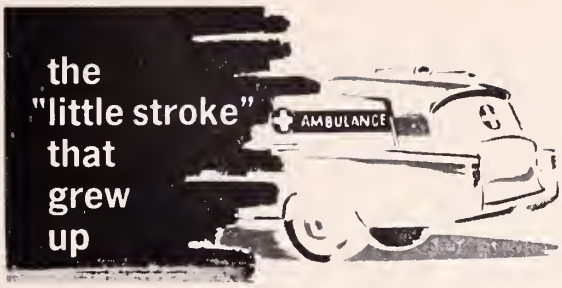
Dr. Alvin C. Theiler, Kiel, recently was the principal speaker at the dinner meeting of the Kiwanis, Lions and Rotary Clubs held in Two Rivers. Doctor Theiler, honored as "Kiwanian of the Year" in 1964, is district chairman of "Key Club," a youth organization in high schools of the nation, sponsored by Kiwanis International.

Doctors Featured on Heart Disease Panel

Drs. William A. Mudge, Kenosha, *Henry H. Gale*, Milwaukee, and *Thomas Puchner*, Milwaukee, recently participated at the Heart Disease conference held in Kenosha. Doctor Gale, director of the cardiovascular laboratory at Lutheran Hospital, Milwaukee, had as his topic, "Stress—Its Cause and Effect Relationships of Heart Disease," and Doctor Puchner discussed "How to Reduce the Risk of Heart Attack."

Dr. Bibler Named Head of Division

Dr. Richard Bibler, Menomonee Falls, medical staff president of Community Memorial hospital, has been named chairman of the initial gifts division of the hospital's expansion campaign. The campaign has as its goal a minimum of $850,000.



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[1] Gale, E. T. and Thewlis, M. W., Geriatrics 8:80, 1953
[2] Personal Communication: R. C. Brunner, Pharmaceutical Div., Sunkist Growers

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Dr. Dahl Opens Practice

Dr. Diane A. Dahl, Chippewa Falls, recently began private practice there. She is presently a staff physician at the Northern Colony, holds membership in the American Academy of General Practice, and is secretary-elect of the Chippewa County Medical Society.

Dr. Petersen Honored

Dr. Roger Petersen, Elkhorn, recently was honored as one of the "outstanding young men" of the community by the Elkhorn Jaycees. Doctor Petersen has been in Elkhorn for 16 months and has been the acting secretary–treasurer of the Walworth County Medical Society, board member of the Elkhorn Kiwanis club, volunteer worker with the Red Cross bloodmobile, and active as a member of the medical staff at Lakeland hospital.

Dr. Sorenson Named Head of Staff

Dr. Harold E. Sorenson, Eau Claire, recently was elected chief of the medical staff at Luther Hospital in Eau Claire. Other officers elected were *Drs. R. O. Bjurstrom*, vice-chief-of-staff; *R. C. Brown*, secretary–treasurer; *Ralph F. Hudson* and *T. D. Moberg* were placed on the executive committee of the medical staff.

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Currently there are 175 tapes which are reviewed and updated annually. Additional recordings are being made. It is hoped that this service will help deliver optimal health care. Any suggestions for modifications or titles are always welcome.

Brochures listing all of the titles by number and classification were mailed Jan. 1 to all Wisconsin physicians through their hospital medical staffs. Also, brochures have been posted on hospital bulletin boards, and as new recordings are made these will be added.

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To handle calls in the Milwaukee Toll-Free area, a duplicate library has been installed in Milwaukee County Hospital, and all doctors in the Milwaukee Toll-Free area are urged to use the service by dialing 258–9500. Those in the Madison Toll-Free area are urged to place their calls by dialing 262–4515.

All other doctors in Wisconsin should use the special WATS (Wide Area Telephone Service) line installed in Madison by dialing long distance in the normal manner from their home community, and then dialing 800–362–8183. If doctors have difficulty, they should contact their local operator who will tell them how to dial to get onto the WATS line.

If brochures have been mislaid, they may be obtained by writing to: Mr. Roy T. Ragatz, Coordinator, Postgraduate Education Committee, Wisconsin Regional Medical Program, 333 N. Randall Ave., Madison, Wis. 53706.

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Dr. Petersen Instructs Policemen

Dr. George J. Petersen, Appleton, recently discussed emergency childbirth before the Fox Valley policemen. He illustrated his presentation with a sound-color movie.

Dr. Holtey Guest Speaker

Dr. Warren J. Holtey, Marshfield, anesthesiologist with the Marshfield Clinic, spoke on the Bloodmobile program at the November meeting of the Marshfield Business and Professional Woman's Club. Doctor Holtey, former chairman of the Bloodmobile program, thoroughly discussed the booklet entitled "What Everyone Should Know About the Red Cross Blood Program and How It Saves Lives."

Dr. Quisling Appointed President

Dr. Abraham A. Quisling, Madison, recently was named president of the Madison Chamber of Commerce. His duties started Jan. 1, 1968.

Dr. McCullough Elected Chief-of-Staff

Dr. John C. McCullough, Fond du Lac, recently was elected chief-of-staff of St. Agnes Hospital succeeding *Dr. Harvey Sharpe, Jr. Dr. Herman Thomas, Jr.* was reelected secretary and *Dr. Arnold Bissegger* was named to a three-year term on the executive committee. Doctor McCullough is a former president of the Fond du Lac County Medical Society.

Dr. Lokvam Returns from Vietnam

Dr. L. H. Lokvam, who traveled to Vietnam last fall to serve the civilian population through the American Medical Association Volunteer Physicians for Vietnam, was stricken with a series of conditions which hospitalized him shortly after arriving in the country. The seriousness of his illness caused his early return to the United States and home to Kenosha. But his short visit there gave him an opportunity to experience first hand the medical and civilian problems of the war-torn country. His impressions have been published in a series of articles entitled, "A Doctor's Diary," in the KENOSHA NEWS.

Prof. Steenbock Passes

Harry Steenbock, Ph.D., who had received the State Medical Society's Council Award in 1953, died Christmas Day in Madison. Professor Steenbock was regarded as the discoverer of the usefulness of vitamin D. His entire scientific experimentation was conducted in the laboratories of the University of Wisconsin where he obtained his B.S., M.S., and Ph.D. degrees, the latter in 1916.

Dr. Magnin Joins Clinic

Dr. Dean A. Magnin, Lena, recently joined the staff of the Boren Clinic, Marinette. Doctor Magnin graduated from the University of Wisconsin Medical School and served his residency in Ohio.

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REFERENCES:

1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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PHYSICIAN NEWS *continued*

Participates in AMA Mental Health Meeting

A Wisconsin physician was one of eight selected state medical society representatives invited to participate in a meeting in October at AMA headquarters in Chicago to discuss means of improving the effective functioning of the state society mental health committee as it relates to ongoing liaison with the AMA Department of Mental Health. The AMA has been concerned with how it could better stimulate, encourage, and help state committees develop more useful activities.

Dr. Albert A. Lorenz of Eau Claire, chairman of the State Medical Society's Division on Nervous and Mental Diseases of the Commission on State Departments, was selected for participation because of his interest and past performances in the area of mental health. Other participants were from the states of Colorado, Mississippi, Oklahoma, Tennessee, New Jersey, Oregon, and North Carolina.

Among items under discussion were the potential role of the state mental health committee as a monitor or evaluator of the various mental health programs in the states; establishment of relationships with other groups such as medical schools' departments of psychiatry, state departments of mental health and state government, specialty groups of organized medicine, regional organizations (such as SREB, WICHE), other professionals and the general public; how the AMA can assist committees through programs such as continuing education, seminars, state conferences and congresses, exhibits and printed material, and through the use of AMA Field Service staff; and means of improving communication between the states and the AMA, as well as among the various state medical societies in the area of mental health.

Abstract in Surgery Digest

The scientific article, "Femoral Popliteal Arterial Reconstruction," which appeared in the April 1966 issue of the WISCONSIN MEDICAL JOURNAL, was abstracted in the October 1967 issue of SURGERY DIGEST. Authors are *Drs. D. W. Cline* and *G. B. Murphy* of La Crosse.

Dr. Peterman to Virginia

Dr. M. G. Peterman, who returned to Milwaukee November 1 from Arlington, Va., has accepted a position of medical director for the National Children's Rehabilitation Center in Leesburg, Va. In this new capacity he will organize a research program in epilepsy.

After 39 years of private practice in pediatrics in the Milwaukee area, Doctor Peterman gave up his practice in November 1964 to take a position with the Food and Drug Administration in Washington, D.C. He had returned to Milwaukee last fall, not in retirement, but to continue in consultative work particularly in neurology.

COUNTY SOCIETY PROCEEDINGS

CRAWFORD

In late 1967 the Crawford County Medical Society presented a $500 check to the Prairie du Chien Rescue Squad whose 16 members are training in First Aid during these winter months. The money supports the operation and new equipment for the service unit. Local doctors are assisting in the lecture and practice sessions.

The Society in December contributed $500 to the CES Foundation of the State Medical Society in support of the Museum of Medical Progress at Prairie du Chien.

DANE

Dr. F. J. L. Blasingame, executive vice president of the American Medical Association, Chicago, was guest speaker at the regular meeting of the Dane County Medical Society, Dec. 12, at the Hoffman House West in Madison. His topic was "Current National Problems in Medicine."

The Society was informed by the City of Madison Welfare Department that beginning Jan. 1, 1968, the cost of medical care to the City of Madison welfare clients would be based on the current concept of usual, customary and reasonable fees for medical services rendered. The Welfare Department will make payment directly to the doctors. *Dr. C. O. Vingom* of Madison continues as the coordinator.

DODGE

Dr. Elmer R. Taake of Beaver Dam assumed the presidency of the Dodge County Medical Society Jan. 1. Secretary–treasurer is *Dr. Darrell L. Link* of Beaver Dam. *Dr. William G. Richards* of Beaver Dam is delegate and *Dr. Fred A. Karsten* of Horicon is alternate delegate to the State Medical Society for the 1968 annual meeting in May.

DOUGLAS

A Superior psychologist, J. DeLucia, addressed members of the Douglas County Medical Society at its meeting Jan. 3 in Superior. He is head of the Department of Psychology at Wisconsin State University–Superior and explained the work which has been done in Douglas County toward a comprehensive mental health center at Superior. He further explained that to qualify for federal funds a center must provide at least five essential services: (1) inpatient care, (2) outpatient care, (3) partial hospitalization, (4) emergency care, [24-hour emergency service is to be available in one of the three Superior hospitals], and (5) consultation and education.

These services are in addition to the current services now available: (1) outpatient care, (2) diagnostic evaluation, (3) consultation and education, (4) after-care [on a limited basis], and (5) community mental health planning. The Society voted endorsement of this program pending the qualification for state or federal aid.

During the business session members discussed the feasibility of better physical examinations for school athletes. Examinations have been done in mass fashion. The School Health Committee was directed to study the situation and report back.

Dr. Oscar A. Farias of Hawthorne announced that there have been six speakers engaged for scientific programs during 1968. Arrangements were completed with the Speakers Service of the State Medical Society through the CES Foundation.

MILWAUKEE

Dr. Howard L. Correll, a heart specialist, was named president-elect of The Medical Society of Milwaukee County at the Society's annual meeting Dec. 14 at the Athletic Club in Milwaukee. New president, who took office at the meeting, is *Dr. George E. Collentine, Jr.*, a surgeon and director of St. Mary's Hospital Burn Center.

Doctor Correll is an associate clinical professor of medicine at Marquette School of Medicine and a consultant in cardiology at the Veterans Administration Hospital, Wood. He is a past president of the Wisconsin Heart Association.

Doctor Collentine urged Society members to participate in affairs of the community and the medical society. He said that solutions to controversies over health care, hospital staff privileges, union medical centers, hospital area planning and multi-phasic screening programs best could be resolved if doctors were fully informed.

The Society's outgoing president, *Dr. Christopher R. Dix* of Milwaukee, urged participation in society affairs. "The time is here," he said, "for orderly and meaningful change—not in ethics, devotion or concern, but rather in the more material features of the efficiency methods of delivery and cost of the service we render to people."

Dr. John R. Evrard of Milwaukee was elected secretary and *Dr. David J. Carlson* of Milwaukee was elected treasurer.

ONEIDA–VILAS

The Dec. 11 meeting of the Oneida–Vilas County Medical Society was held in Rhinelander with Dr. Alan Colin Markland of Minneapolis as the guest speaker. Doctor Markland, who is associate profes-

Physicians whose names appear in italics are members of the State Medical Society.

sor of urology at the University of Minnesota Medical School, discussed "The Management of Urinary Tract Infections in Children."

The following officers were elected during the business session: *Dr. Murray A. Litton* of Rhinelander, president; *Dr. John F. Brown* of Rhinelander, vice-president; and *Dr. Marvin Wright* of Rhinelander, secretary–treasurer. Doctor Wright was also named delegate and *Dr. Henry S. Ashe* of Minocqua, alternate delegate, to the 1968 annual meeting of the State Medical Society.

OUTAGAMIE

Members and wives of the Outagamie County Medical Society honored one of its members at a holiday dinner party in December. *Dr. Guy Carlson*, who has served the Appleton community for more than 40 years, received a silver pitcher with the inscription, "We thank you, Guy, for your many years of service and your tireless efforts on behalf of our society and the practice of medicine."

Doctor Carlson has held all offices in the county society, has been a delegate to the State Medical Society for many years, and served on the State Society Council. For the past 20 years he has served on the State Society's Commission on Medical Care Plans, the governing body for Wisconsin Physicians Service, Blue Shield insurance division.

A SPECIAL AWARD for outstanding service to the Appleton community was presented to Dr. Guy Carlson, left, by Dr. James Gmeiner, president of the Outagamie County Medical Society at the Society's annual meeting in December. Doctor Gmeiner also received a plaque in appreciation of his service to the community and the medical society. (Appleton Post–Crescent Photo)

He has been active in the YMCA, Red Cross, and has done tuberculosis testing in the schools for 25 years. He also served as a medical examiner for the Selective Service System for 25 years. He opened his practice in Appleton in 1923, following graduation from Rush Medical College, Chicago, and an internship at St. Luke's Hospital in Chicago.

RACINE

The successor to Dr. Albert Schweitzer, world-famous jungle doctor who died two years ago at age 90, spent two days at the Johnson Foundation in Racine late last year. He is Dr. Walter Munz who was hand-picked by Doctor Schweitzer to succeed as director of the Lambarene Hospital in Gabon, West Africa. The Swiss doctor came to the United States to receive the Lions International Humanitarian Award on behalf of the Schweitzer hospital. He also was seeking to raise funds.

Doctor Munz addressed members of the Racine County Medical Society in November and the next day addressed Milwaukee physicians at Wingspread, the conference center of the Johnson Foundation.

RICHLAND

New officers of the Richland County Medical Society elected at the Dec. 12 meeting in Richland Center are: *Dr. Julius H. Kelertas* of Richland Center, president; *Dr. Donald J. Taft* of Richland Center, vice-president; and *Dr. L. Maramon Pippin* of Richland Center, secretary–treasurer.

Dr. Richard W. Edwards was named delegate and *Dr. George Parke, Jr.* of Richland Center, alternate delegate, to the State Medical Society's 1968 annual meeting in May.

WALWORTH

At the Dec. 14 meeting of the Walworth County Medical Society at Lake Geneva the following new officers were elected: *Dr. Rocco S. Galgano* of Delavan, president; *Dr. Boyd C. Hindall* of Lake Geneva, vice-president; and *Dr. Orhan G. Bingol* of Walworth, secretary–treasurer.

WAUKESHA

Dr. Joseph R. Matt of Oconomowoc is the new president of the Waukesha County Medical Society. Other officers are: *Dr. John L. Raschbacher* of Big Bend, president-elect; *Dr. W. J. Kilbourn Clothier, Jr.* of Waukesha, treasurer; and *Dr. Constance R. Erwin* of Elm Grove, secretary. Named as the executive secretary is Gale P. Brennan of Brookfield.

Mr. Brennan is president of Communications, Inc., a Milwaukee writing and publishing firm and heads Gale Brennan and Associates, a public relations and advertising counsel. His duties will be to assist the Society with various administrative functions of the organization as directed and to provide assistance and counsel to the physicians group in matters relating to public information and interest.

SPECIALTY SOCIETY PROCEEDINGS

Milwaukee Orthopedic Club

New officers of the Milwaukee Orthopedic Club are: *Dr. Louis Kagen*, president; *Dr. James A. Groh*, president-elect; *Dr. Paul A. Jacobs*, secretary; and *Dr. E. Kenneth Rath*, treasurer.

Milwaukee Academy of Medicine

Dr. Marvin H. Sleisenger, professor of medicine, The New York Hospital–Cornell Medical Center, was guest speaker at the Dec. 12 meeting of the Milwaukee Academy of Medicine at the University Club of Milwaukee. His subject was "Protein Losing Enteropathy."

Doctor Sleisenger was also the 1967 visiting professor of the Academy and he participated in Grand Rounds and Case Presentations at Columbia Hospital, Milwaukee County General Hospital, Veterans Administration Hospital, and Milwaukee Children's Hospital during his three-day visit in Milwaukee.

The 82nd annual dinner meeting of the Academy was held Jan. 16 at the University Club. Dr. John L. Caughey, associate dean, Western Reserve University School of Medicine, lectured on "Medical Education, What Next?".

Doctor Caughey expressed his opinion that today's medical manpower crisis arises not so much from a doctor shortage as a doctor imbalance. He said United States schools were training too many doctors who derived their main satisfaction from solving research problems—transplanting the heart would be an extreme example— and were not interested in patient care.

New officers installed for 1968 are: president—*Dr. Edward A. Bachhuber;* president-elect—*Dr. Bruno J. Peters;* vice-president—*Dr. Robert W. Byrne;* secretary—*Dr. Paul G. LaBissoniere;* treasurer—*Dr. Donald P. Babbitt;* and librarian—*Dr. Richard D. Fritz. Dr. Norman B. Hodgson* is chairman of the membership committee.

Wisconsin Psychiatric Association

The annual scientific meeting of the Wisconsin Psychiatric Association and the Wisconsin Psychological Association was held Feb. 2–3 at the Park Motor Inn in Madison. The scientific and social functions were open to all interested members of related professions.

Guest speakers included: Marvin Hersko, Ph.D., professor of psychology, Wisconsin State University–Whitewater; Dr. Stanley Lesse, editor-in-chief, AMERICAN JOURNAL OF PSYCHOTHERAPY, New York City; *Dr. Arnold J. Marx*, associate chief, Special Treatment Unit, Mendota State Hospital, Madison; O. Hobart Mowrer, Ph.D., research professor, Department of Psychology, University of Illinois, Urbana, Ill.; Morton S. Perlmutter, Ph.D., assistant professor, Department of Social Work, University of Wisconsin, Madison; Dr. James Q. Simmons, III, chief, Children's Inpatient Service, UCLA Neuropsychiatric Institute, Los Angeles, Calif.; and Dr. Carl A. Whitaker, professor of psychiatry, University of Wisconsin, Madison.

Presidents of the two groups are: *Dr. Leigh M. Roberts* of Madison and Paul H. Whiteman, Ph.D., of Milwaukee. Dr. Arnold M. Ludwig of Madison was program chairman. The meeting had as its theme: "The Ends and Means Dilemma in Therapy."

Wisconsin Society of Anesthesiologists

At the October meeting of the Wisconsin Society of Anesthesiologists the following officers were elected: president—*Dr. Frederick D. Cook*, Green Bay; president-elect—*Dr. Robert M. Schuyler*, Milwaukee; secretary—*Dr. Ruth A. Stoerker*, Madison; and treasurer—*Dr. Irving Wright*, Brookfield. Immediate past president is *Dr. Robert O. Bjurstrom*, Eau Claire.

The Board of Directors consists of *Drs. Sheldon Burchman*, Milwaukee; *William Kreul*, Racine; *Robert E. Holzgrafe*, Milwaukee; *Philip A. Hoffman, Jr.*, Madison; and *Frederick Carpenter*, Wauwatosa. Delegates to the American Society of Anesthesiologists are *Drs. Gordon Garnett*, Madison; and *Loron Thurwachter*, Milwaukee; alternate delegates, *Dr. William Mateicka* and *Robert M. Schuyler*, Milwaukee.

Named to the State Medical Society's Section on Anesthesiology were Doctor Cook, chairman; Doctor Stoerker, secretary; Doctor Burchman, delegate; and *Dr. John W. Temple*, Wauwatosa. *Dr. Karl L. Siebecker* was named representative to the State Medical Society's Commission on Public Policy.

Wisconsin Allergy Society

New officers of the Wisconsin Allergy Society are: president—*Dr. David M. Glassner*, Milwaukee; president-elect—*Dr. Abe Sosman*, Milwaukee; secretary–treasurer—*Dr. Jordan N. Fink*, Milwaukee. At the October meeting approval was given for residents and fellows to be guests of the Society at its future annual meetings. The next annual meeting will be held in Milwaukee in May 1968 in conjunction with the State Medical Society's annual meeting.

* * *

FIVE CASES OF Asian flu in Wisconsin this winter have been confirmed so far by the State Laboratory of Hygiene, according to virologist, Donald B. Nelson.

Physicians whose names appear in italics are members of the State Medical Society.

Physiatrist Joins Sacred Heart Hospital

Dr. Basilio Lopez has joined Sacred Heart Rehabilitation Hospital in Milwaukee as chief of the physical medicine and rehabilitation department.

A native of Spain, Doctor Lopez has been associate director of physical medicine and rehabilitation at Highland View Hospital in Cleveland, Ohio. He was also an assistant professor on the faculty of Western Reserve University, Cleveland.

At Sacred Heart, Doctor Lopez heads a department which within the last two years has been expanded for the care of all chronic diseases and physical disabilities. New equipment has been added and the department staff enlarged to provide for complete physical, occupational and speech therapy.

Doctor Lopez is a 1952 graduate in medicine of Madrid University in Spain. His postgraduate training was obtained in Spain, at New York University, and at St. John's General Hospital, St. John's, Newfoundland, Canada.

Doctor Lopez is a board certified physiatrist. He is a member of the American Academy of Physical Medicine, the Midwestern Physical Medicine Society, the American Medical Association, and the Newfoundland Medical Society.

Management by Objectives: UW Hospitals

A management program which may improve hospital operation has been implemented and is being tested at University of Wisconsin Hospitals. The program, called Management by Objectives, has been used in industry, but has been applied in few hospitals, according to Edward J. Connors, hospital superintendent.

Assistant Prof. David E. Schrieber and Mr. Stanley Sloan, both of the University's Management Institute, will help the Hospitals design, implement, and evaluate the program.

Nationally, Connors said, hospital managers are faced with rising costs, rapidly changing technology, severe manpower shortages and increased responsibility in the health services system. Consequently, it is mandatory in Connors opinion, that hospitals actively seek methods of achieving greater efficiency and economy of operation.

Schrieber pointed out that several large profit-making enterprises which have adopted the management objectives program claim the program resulted in increased productivity, lowered costs and improved employe morale.

The program was described by Schrieber and Sloan as a managerial method whereby hospital personnel identify objectives to be accomplished in all major areas of hospital operation. The program defines the limits within which the various personnel can operate and sets specific performance standards. It then is determined how and by what time these standards should be achieved so that the progress can be evaluated.

Physicians whose names appear in italics are members of the State Medical Society.

PARAMEDICAL ANCILLARY GROUPS

Disease Prevention Program

The Hustisford Lions Club has given support to a disease preventive program for children entering the public and private schools of Hustisford. The program will be carried out from spring to fall every year. The following tests and immunizations will be done: TB test, urine examination for diabetes and kidney trouble, measles, DT, polio, and smallpox vaccination. There will be no charge for the tests and immunizations.

Comprehensive Mental Health-Care Program for Five Counties

Expansion of a comprehensive mental health-care program has been adopted for a five-county area including Barron, Burnett, Polk, Rusk, and Washburn. The Barron–Polk Guidance Clinic, Turtle Lake, in surveying physicians found that an additional 325 patients could have benefited from short-term inpatient care and another 300 could have used day hospital services had they been available. At present approximately 1,400 persons, or about 1.7 per cent of the total population in the original four-county (Barron, Burnett, Polk, and Washburn) area served have received outpatient services from the guidance clinic. Other facts showed that 86 persons from that area were admitted to state mental institutions during the past year, and twice that number hospitalized at private institutions. These and other facts presented at the fall session of the five county boards prompted the expansion of the program.

Adolescent Care Center Opened

The Wisconsin State Department of Health and Social Services in January approved the opening of a residential treatment center for adolescents at Eau Claire. Residents of the center, between the ages of 8 and 18, are offered group therapy and activity therapy, as well as facilities for classroom education in regular school studies, and the services of a professional staff for counseling service both to residents and their families. Called the "Albert A. Lorenz Institute," it is located in the former Sacred Heart Hospital buildings, which have been extensively remodeled and modernized. The therapeutic program uses the staff of the Northwest Psychiatric Clinic. A group of doctors is available as consultants in the department of research. The institute will be able to extend care and treatment to about 66 residents in the immediate future.

Two-year Nursing Program at Wausau

Authorization has been granted to the Marathon County Technical Institute to proceed with architectural plans for accommodating a two-year associate degree nursing program. The authorization was given by the State Vocational, Technical, and Adult Education board and the State Coordinating Committee for Higher Education. The project has also been endorsed by the State Division of Health and the Governor's Task Force on Medical Education.

Extensive interest has been expressed in this two-year nursing program since the closing of the three-year nurses training program at St. Mary's Hospital in Wausau. The Technical Institute effort has been endorsed by St. Mary's and Memorial hospitals, Marathan County Medical Society, and other community organizations.

WRMP Resource Study Group

Donald C. Slichter has been appointed chairman of the Resource Study Group, a newly created committee of the Wisconsin Regional Medical Program, it was announced in January by Edmund Fitzgerald, president of the organization.

Serving with Mr. Slichter will be *Dr. Peter L. Eichman*, Dean of the University of Wisconsin Medical School; *Dr. Gerald A. Kerrigan*, Dean of Marquette School of Medicine, Inc.; *Dr. Harold J. Kief*, Fond du Lac, currently President of the State Medical Society of Wisconsin; Gordon Kenngott, Vice-President, Milwaukee Chaplet & Manufacturing Co., Inc., New Berlin; Bertram McNamara, Director of District No. 32, United Steel Workers of America, Milwaukee; Karl H. York, Racine, Administrator, St. Luke's Hospital; Harold F. Loeffler, Milwaukee, Chief Engineer, Wisconsin Telephone Company.

Mr. Slichter was chairman of the Governor's Task Force which several weeks ago completed and submitted its report on medical education to Governor Knowles. It is the most comprehensive study of its kind ever undertaken in the state. Mr. Slichter, who recently retired as president of Northwestern Mutual Life Insurance Company, is a prominent civic and business leader long active in many organizations concerned with health education and community welfare.

The Resource Study Group will study the relationship of service, education and research to facilities, manpower, equipment, funds, and information as they pertain to the objectives and operations of the Wisconsin Regional Medical Program.

The Wisconsin Regional Medical Program, Inc., was established in July 1966 with federal planning funds. Enabling legislation for regional medical programs was passed by Congress in 1965. The purpose of the enabling legislation is to help make the best in modern medical science available as quickly as possible to people ill with heart disease, cancer, stroke, emphysema, and related diseases.

The primary method in reaching the objectives of regional medical programs is encouraging cooperative efforts of existing health and educational resources throughout the region. *Dr. John S. Hirschboeck*, former Dean of Marquette Medical School, is coordinator of the Program.

Doctor Hirschboeck stated that Mr. Slichter's committee will be assisted by Roger Hamilton, assistant director of the Wisconsin Hospital Association, who has been retained to serve the Planning Committee of the Wisconsin Regional Medical Program on a part-time basis. One of his major responsibilities at the Wisconsin Hospital Association is to implement the program of Wisconsin Health Careers Council. Also assisting the Resource Study Group will be Paul Nutt, a member of the Planning staff and James H. Sullivan, assistant regional program coordinator.

St. Francis Extended Care Facility Planned

St. Francis Hospital in Milwaukee will build a new 150-bed Extended Care Facility as an addition to its present hospital building this year. Sister M. Paschalisa, Administrator, revealed plans for the three-story, Extended Care Facility in an announcement to the medical staff.

The new addition will cost approximately $2,000,000 and will be financed by funds supplied by the Felician Order of Sisters and in part through private loans. No public fund drive is contemplated.

Planning for the new facility has been in cooperation with the Hospital Area Planning Committee of Milwaukee and its staff members.

Marquette Liver Study Given Grant

A grant of $226,206 has been awarded to Marquette School of Medicine by the John A. Hartford Foundation, New York City, for further development of a safe, reliable support system to treat patients in acute liver failure. The January announcement of the three year research award was made jointly by Ralph W. Burger, foundation president, and *Dr. Gerald A. Kerrigan*, dean of the medical school.

Dr. Joseph C. Darin, associate professor of surgery and head of the Marquette liver team, has been working on development of a support system based on perfusion since 1965. In the past year, he has treated five patients, four of whom received support from a human cadaver liver. Human cadaver liver support was first tried in the United States by the Marquette team. The fifth patient was supported with a goat liver whose use has been initiated at Marquette. The method has reached a point of technical success and with the Hartford grant, significant improvements will be possible and unsolved aspects of liver failure explored.

Vincent Otis Has New Position

Dr. E. H. Jorris, State Health Officer, announced in January the appointment of Vincent F. Otis as deputy director of the recently established Bureau

of Comprehensive Health Planning in the Division of Health. Mr. Otis was transferred to his new post from his position as chief of the Section of Hospital and Related Services which he had held since 1947.

Mr. Otis was born in Milwaukee and was trained there as an accountant. Before joining the State Board of Health in 1945 he served as an administrator at the Milwaukee county institutions, and as an accountant for the State Department of Agriculture.

He has served on numerous state and national committees involved in health and hospital planning and programming. He has written for a number of state and national health publications, and has addressed many health meetings.

Last spring Mr. Otis was presented the annual award of merit of the Tri-State Hospital Assembly and was honored in 1963 by the Wisconsin Association of Nursing Homes and in 1959 by the Wisconsin Hospital Association.

Careers in Rehabilitation Scholarships

Two scholarship programs for students preparing for careers in rehabilitation fields are announced by the National Easter Seal Society for Crippled Children and Adults. The scholarships are sponsored by Alpha Chi Omega Women's Fraternity and Kappa Delta Phi Sorority.

The Alpha Chi Omega program of supplemental aid scholarships is a new project to assist students working toward Master's degrees in speech pathology or audiology. Kappa Delta Phi scholarships are available for students in their final year of training as physical or occupational therapists.

The Alpha Chi Omega scholarships will be granted in amounts up to $750 toward a student's support during the course of a full academic year. They must be recommended by the department head or a ranking faculty member of a Master's degree program accredited by the American Speech and Hearing Assn. Deadline for applications is July 15, 1968, and awards will be announced in August.

The Kappa Delta Phi scholarships will range from $100 to $500. Applications must be accepted in a certificate course or be in the senior year or the clinical training period of a degree course in occupational or physical therapy in a school approved by the Council on Medical Education and Hospitals of the American Medical Association. Applications will be considered by a scholarship committee on the basis of scholastic achievement and financial need. The deadline for applications is May 1, 1968.

For information, write to Scholarship Coordinator, Educational Services, National Easter Seal Society for Crippled Children and Adults, 2023 W. Ogden Avenue, Chicago, Illinois 60612.

Seminar on Computers, Luther Hospital

A one-day seminar on computers was held Jan. 13 at Luther Hospital, Eau Claire. The unique program, first of its kind presented, included specialists in the field of medical computer application.

WRMP Staff Appointments

Miss Martha R. Jenny has joined the staff of the Wisconsin Regional Medical Program as Nursing Coordinator. Her duties will consist of providing staff support for the Nursing Committee as well as for other committees of WRMP. Miss Jenny directed the survey of health conditions among the Menomonee Indians, sponsored by the State Medical Society of Wisconsin, in 1964 and has been more recently on other similar assignments in Kentucky and Arizona.

Dr. J. D. Kabler has joined the staff as an assistant to *Dr. Robert O. Johnson*, assistant program coordinator, at the WRMP office at 333 North Randall Avenue in Madison. He will be working with the faculty of the University of Wisconsin. He will also represent the staff of WRMP as a member of the Stroke Study Group Steering Committee.

The Planning Committee has announced the appointment of Ray L. Guy, associate executive, United Community Services of Milwaukee, to the Committee, replacing Eugene M. Cox, who resigned when he moved to New York. Peter J. Sheldon, ACSW, program coordinator, Department of Social and Community Medicine, Division of Preventive Medicine, Marquette School of Medicine, to the Measurement and Data Collection Subcommittee of the Planning Committee.

FOR YOUR INFORMATION

From the Wisconsin Division of Health

Although Wisconsin has been without a confirmed case of polio since 1964 when the mass immunizations were carried out, the U.S. Surgeon General,

Birth Defects Treatment Center Established at Marquette

Establishment of a Birth Defects Treatment Center in Milwaukee was assured in December when the Marquette School of Medicine announced that it had received a yearly grant of $34,416 for the Center.

The Center, which became effective January 1, is financed by the Milwaukee and other Wisconsin County Chapters of the March of Dimes and will be under the direction of the Department of Pediatrics of the Marquette School of Medicine.

Dr. John C. Peterson, chairman of the Pediatrics Department, has indicated that the function of the Center will be to provide a comprehensive multi-disciplinary diagnostic, evaluative, therapeutic and/or correction program for infants and children with any of a broad range of birth defects referred to the Center.

The National Foundation estimates that in Milwaukee County 1,500 babies are born annually with birth defects and that over 5,000 such babies are born in the state of Wisconsin.

William H. Stewart, warns of the danger of an increase in the number of cases.

Doctor Stewart predicts that "if all newborn infants are not protected as they come along cases can occur among those exposed to the disease." He attributes a rise in the number of cases in 1966, though small in numbers, to complacency about the threat of polio and the decreased use of vaccine in high risk groups.

The percentage of children one through four with adequate immunization against polio dropped from 74 per cent in 1965 to 70 per cent in 1966.

PKU TESTS HELP FIND 3 CASES

Of 57 Wisconsin infants whose blood tests in 1967 were suspicious for PKU, three were diagnosed as suffering from the disease, according to the Wisconsin Division of Health. PKU testing became mandatory in Wisconsin Jan. 1, 1966.

In the first year the law was effective, 61 babies were suspected of PKU; 8 were found to have the disease. About 80,000 infants were born in Wisconsin in 1966. The number for 1967 has not been released yet, but it is expected to be somewhat fewer.

MILWAUKEE INSTITUTIONS COORDINATE MEDICAL SERVICES FOR ILL AND HANDICAPPED CHILDREN

A plan to coordinate and integrate the medical services for ill and handicapped children served by Milwaukee Children's Hospital and the Curative Workshop of Milwaukee with Marquette School of Medicine has been approved by the boards of directors of the three organizations. The plan which aims to avoid unnecessary duplication of facilities and energies was jointly announced in November by Mrs. Erwin C. Uihlein, president, Children's Hospital; Allen M. Taylor, president, Curative Workshop; and John H. Kopmeier, Board of Directors, Marquette School of Medicine.

Representatives from the Hospital, Workshop, and Medical School have reviewed, for several months, the possibility of stronger affiliation in the areas of medical diagnosis, treatment, and rehabilitation. The study committee concluded that outpatient medical services of the institutions should be coordinated and that supervision by the department of pediatrics of Marquette School of Medicine would strengthen educational and research activities. They recommended that a permanent joint planning committee be set up with representatives from each organization. The new planning committee held its first meeting on November 9 to work out details for coordinating efforts.

The separate identities of each institution will be maintained as well as its respective facilities and services. Their primary areas of concentration differ. Children's hospital services are primarily for medical diagnosis and treatment over relatively short periods of time while Kiwanis Children's Center of the Curative Workshop provides comprehensive rehabilitation services requiring long periods of treatment.

A statement issued in announcing the program stressed that basic goals are identical—the highest possible degree of excellence in medical and other rehabilitation services provided ill and handicapped children. The planning committee will implement joint objectives by a constant review of all present medical programs of both institutions, by consideration of possible changes in them, and by recommending development of new medical programs to integrate services and facilities for care, treatment, and rehabilitation of children. Consideration will be given to the feasibility and advisability of future development on adjoining sites of the outpatient facilities of the Hospital and Workshop.

Other community agencies which are providing medical care, treatment, and rehabilitation services for disabled children will be encouraged by the committee to participate in the program. The announcement emphasized that the close affiliation of the three institutions is consistent with plans now being widely discussed to coordinate medical, hospital, and rehabilitation efforts through a medical center complex for the greater Milwaukee area.

Members of the permanent planning committee for Children's Hospital are Mrs. Erwin C. Uihlein, president; Richard Seaman, vice president; Edward J. Logan, administrator, and Frederic Blodgett, M.D., medical director of the outpatient department. Representing the Curative Workshop are Allen M. Taylor, president; Donald L. Bell, vice president; T. S. Allegrezza, administrator, and Harold Cook, M.D., medical director. The Marquette School of Medicine will be represented by John H. Kopmeier, a member of the Board of Directors; John C. Peterson, M.D., Chairman, Department of Pediatrics; and John W. Harkness, M.D., Assistant Dean, Marquette School of Medicine.

John H. Kopmeier was elected Chairman and Edward J. Logan was elected Secretary–Treasurer of the newly created joint planning committee.

OBITUARIES

Dr. J. J. Kronzer, 62, Oshkosh, died Sept. 1, 1967, in Oshkosh.

Doctor Kronzer graduated from the Marquette University School of Medicine in 1931 and took his internship at Mercy Hospital in Oshkosh. He was the former city physician and medical examiner for the police and fire board. Doctor Kronzer served with the Medical Corps in World War II, and retired with rank of captain in 1965.

He was a member of the Winnebago County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Lucille; six sons, Lt. Comdr. J. J. Kronzer, Jr., USN, Groton, Conn.; William W., Madison; Lt. James E., USN, London, Eng.; Paul F., Davenport, Iowa; Richard L., Milwaukee; and Peter M., Great Lakes Naval Training Center, Ill.; and three daughters, Mrs. William Martin, Manila, Philippine Islands; Mrs. William C. Bayer, Denver, Colo.; and Margaret, Oshkosh.

Dr. William C. Felton, 86, Appleton, died Oct. 5, 1967, in Milwaukee.

Doctor Felton graduated from the Marquette University School of Medicine in 1916 and interned at Milwaukee County General Hospital. He was a public health officer in Appleton before retiring in 1958.

Surviving is a daughter in Los Angeles and a son in Milwaukee.

Dr. Robert S. Wright, 56, Racine died Oct. 13, 1967, in Racine.

Doctor Wright graduated from the Marquette University School of Medicine in 1938 and interned at Milwaukee County Hospital. His residency was taken at St. Luke's Hospital in Racine. He served in the United States Navy from 1943 until 1946. Doctor Wright was a member of the Racine County Medical Society, State Medical Society of Wisconsin, American Medical Association, and the Industrial Medical Association.

Surviving are his widow, Lorraine; and a son, Robert.

Dr. Louis H. Nowack, 83, Watertown, died Oct. 22, 1967, in Watertown.

Doctor Nowack graduated from the College of Physicians and Surgeons, University of Illinois, in 1908. He began his practice in Watertown at that time and retired in 1946. Doctor Nowack served in World War I and was also city health officer of Watertown for many years.

Doctor Nowack was a former member of the Jefferson County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Rose; a daughter, Mrs. A. C. Hahn, and a son, Dr. Louis W. Nowack, all of Watertown.

Dr. Cornelius J. Corcoran, 76, retired Milwaukee physician, died Oct. 24, 1967, in Milwaukee.

Doctor Corcoran graduated from the Marquette University School of Medicine in 1913 and interned at St. Mary's Hospital from 1913 to 1914. He did postgraduate work at the University of Vienna, Austria, and served in the army medical corps during World War I. Doctor Corcoran was on the staff of St. Mary's Hospital and had served as its staff president. He was a member of the Milwaukee Gastroenterological Society, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Marjorie; two sons, Thomas, Milwaukee, and Cornelius, Jr., Whitefish Bay; two daughters, Mrs. Mary Chinchinian, Clarkston, Wash.; and Mrs. Ann Kaiser, Madison.

Dr. Frederick K. Kolb, 94, retired Howards Grove physician, died Nov. 3, 1967, in Sheboygan.

Doctor Kolb graduated from Northwestern University School of Medicine in 1905 and interned at Chicago Lying In Hospital. He practiced in Illinois and North Dakota before moving to Howards Grove in 1937 where he practiced until his retirement in 1961.

Doctor Kolb was a member of the Sheboygan County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are two sons, Dr. Frederick E. Kolb, Calumet, Mich., and Donald R. Kolb of Spokane, Wash.

Dr. Douglas W. Bailey, 37, Milwaukee, died Nov. 4, 1967, in Milwaukee.

Doctor Bailey graduated from the University of Wisconsin Medical School in 1955. He took his internship at Milwaukee Hospital and served his residency at the Cleveland Clinic, Cleveland, Ohio, and Henry Ford Hospital in Detroit. Doctor Bailey was on the staff with Lovelace Clinic, Albuquerque, and was also consultant to U. S. Public Health Service Indian Hospital in Gallup, New Mexico.

In 1964 Doctor Bailey returned to Milwaukee to enter private practice of orthopedic surgery.

Doctor Bailey was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, American Medical Association, and Milwaukee Orthopedic Club.

Surviving are his widow, Marilyn; and four sons, Daniel, Timothy, David, and James.

Dr. George J. Schweitzer, 82, Milwaukee, died Nov. 7, 1967, in Milwaukee.

Doctor Schweitzer graduated from the Marquette University School of Medicine in 1911 and started his practice in St. Cloud before moving to Milwaukee in 1923. In 1963, he was granted a life membership

continued on page 74

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Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

to The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his four children, Mrs. Katherine Barsema, George J., Jr. of Brookfield, Dr. Robert J., Piedmont, Calif., and Mrs. Jane Seymour of Dearborn, Mich.

Dr. Robert M. Moore, 51, Frederic general practitioner and surgeon, died Nov. 21, 1967, in Minneapolis, Minn.

Doctor Moore, who had been associated with the Frederic Clinic for over 20 years, had been a member of the State Medical Society's Commission on Medical Care Plans since 1950 and had been an inspirational force in the development of Wisconsin Physicians Service, the insurance program of the State Medical Society

Born and raised at Sparta, Doctor Moore took his undergraduate work at the University of Wisconsin, graduating from Northwestern University Medical School in 1940. He served his internship at Methodist Hospital in Madison and continued with a surgical residency at the Jackson Clinic and Methodist Hospital.

He entered the Army medical corps in 1942, serving as flight surgeon with the Air Force. He served overseas for 17 months, serving B-29 bomber crews based in Saipan. Following his discharge in December 1945 he joined the Arveson–Andrews Clinic (now the Frederic Clinic) in Frederic.

His devotion to medicine and his untiring efforts to improve patient care were notable characteristics recognized by his colleagues.

Doctor Moore was a member and past president of the Polk County Medical Society, a member of the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow, Jessie, and four children: Pam, Penny, Robert, and Thomas.

Dr. Joseph L. Kruszewski, 63, Milwaukee, died Nov. 22, 1967, in Milwaukee.

Doctor Kruszewski graduated from the Marquette University School of Medicine in 1931 and took his internship and residency at Milwaukee County General Hospital.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, and the American Academy of General Practice.

Surviving is his widow, Sophia A.

Dr. R. O. Grigsby, 75, Ashland, died Nov. 27, 1967, in Ashland.

Doctor Grigsby, prominent in northern Wisconsin medical circles, retired in 1960 after 36 years of practice. He was a former president and secretary of the Tri-County Medical Society, and was several times president of the staff of St. Joseph's Hospital. He was a member of the 50-year club of the State Medical Society of Wisconsin and also a member of the American Medical Association. Doctor Grigsby was active in the American Academy of Ear, Nose, and Throat and in the American Board of Otolaryngology. In 1966 Doctor Grigsby was honored in recognition of the 50th anniversary of his graduation from Rush Medical College, Chicago.

Surviving is his widow, Mary.

Dr. James D. Walsh, 64, formerly of Mauston, died Dec. 7, 1967, in Rochester, Minn.

Doctor Walsh was senior staff physician at Loretta Hospital and was also on the staff at Rivers Edge and Bethany Hospitals. He graduated from the University of Wisconsin Medical School and studied at the University of Pennsylvania and University of Illinois. He had offices in Milwaukee and Cudahy before moving to Oak Park, Ill. in 1948.

Doctor Walsh was a member of the Stritch School of Medicine, American Medical Association, and formerly a member of the State Medical Society of Wisconsin.

Surviving are his widow, Dorothy; and two children, Michael and Maureen.

Dr. Robert C. Faulds, 98, Abrams, died Dec. 11, 1967, in Abrams.

Doctor Faulds graduated from Oshkosh Normal School and taught at Powers, Mich. He was principal of the old Dousman School in Green Bay in 1893. He studied at the University of Michigan at Ann Arbor and graduated from the Wisconsin College of Physicians and Surgeons in Milwaukee in 1898. He began his practice of medicine in Abrams in 1901 and stayed there until his death.

Surviving are his widow, Lottie; two daughters, Mrs. Perry Betts, Green Bay, and Miss Nora Faulds, Abrams; and one son, James E., Sault St. Marie, Mich.

Dr. John E. Haberland, 69, Milwaukee, died Dec. 15, 1967, in Milwaukee.

Doctor Haberland graduated from the University of Pennsylvania in 1922, did residency work at Wisconsin General Hospital, Madison, and at Columbia Hospital, Milwaukee. His internship was taken at St. Mary's hospital in Madison. Doctor Haberland became a fellow in the American College of Surgeons in 1934 and was a staff member of St. Mary's Hospital in Milwaukee. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Irene; two daughters, Mrs. Robert Hearne and Miss Anne Haberland, and one son, Paul.

Dr. William W. Bauer, 75, Chicago, died Dec. 22, 1967, in Chicago.

Doctor Bauer was educated at the University of Wisconsin and the University of Pennsylvania, and was internationally known as an educator, author, and lecturer. He was associated with the Milwaukee

Health Department and in 1923 moved to Racine to become the city's first health commissioner. In 1931 he moved to Chicago and became the director of the American Medical Association's bureau of health education for nearly 30 years. He served as the associate editor of the AMA's magazine and later took over the editorship. Doctor Bauer has written several textbooks and was also an author of a daily syndicated newspaper column, "Health for Today."

Doctor Bauer was a member of the Racine County Medical Society, and the State Medical Society of Wisconsin before transferring to the Chicago Medical Society in 1933. He was also a member of the American Medical Association.

Surviving are his widow, Florence; a daughter, Mrs. Anne Wetzel, Chicago, and two sons, John R., Chicago and Charles M., Park Ridge, Ill.

Dr. Nicholas M. Mauel, 72, Cashton, died Dec. 30, 1967, in Cashton.

Doctor Mauel graduated from the Marquette University School of Medicine in 1919 and interned at St. Francis Hospital in La Crosse. He began his practice in Potosi and then moved to Cashton where he practiced for 42 years. Doctor Mauel was on the staff of St. Mary's Hospital in Sparta and St. Francis Hospital in La Crosse.

Doctor Mauel was a member of the Monroe County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Cathryn; a daughter, Mrs. Joseph Hamel, Minneapolis; and four sons, Robert, Norwalk; William, Milwaukee; and Rev. John Mauel, rector of Holy Cross Seminary, La Crosse; and Rev. James Mauel, Society of Jesuits, Jesuit College, St. Bonifacius, Minn.

Dr. Fred J. Pfeifer, 88, New London, died Dec. 31, 1967, in New London.

Doctor Pfeifer graduated from the University of Wisconsin in 1905 and then went on to the Marquette University School of Medicine to receive his medical degree. His internship was taken at St. Joseph's Hospital, Milwaukee. Doctor Pfeifer began his practice in New London in 1909 and retired from practice in 1967. He served as city health officer for 43 years and health officer for the Town of Mukwa for 51 years. In 1959, he was honored by the community with a tri-golden anniversary celebration, which marked Doctor Pfeifer's 50th year in medicine, 50th year of marriage, and a golden anniversary of practicing medicine in the city. The event was featured in LIFE MAGAZINE.

Doctor Pfeifer was a member of the Waupaca County Medical Society, the State Medical Society of Wisconsin, and American Medical Association. He was author of the books, "American Brown Water Spaniel" and "Dog World," and was also the first person to have the American Brown Water Spaniel registered as a breed in 1920. His mother, Emma Beck Pfeifer, was one of the first women in the state to become a registered pharmacist.

Surviving are two sons, Charles, Cheboygan, Mich. and Dr. Robert Pfeifer, Fort Lauderdale, Fla.

Dr. E. A. Miller, 97, Clintonville, died Jan. 7, 1968, in Clintonville.

Doctor Miller graduated from Rush Medical College, Chicago, in 1896 and was in general practice until he returned to Chicago where he continued his studies in EENT and graduated in 1921. Doctor Miller returned to Clintonville and practiced until his retirement in 1960.

Doctor Miller was a member of Waupaca County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving is a son, Edward, Evanston, Ill.

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Grand Old Man of Medicine

Dr. Fred J. Pfeifer was more than just a doctor to New London. The grand old man of medicine who died Sunday was an understanding friend, a tireless worker, a compassionate nurse, a farseeing developer, a tenacious guardian and in the end, a legend. And the city knows it and mourns his death.

When Dr. Pfeifer arrived in New London in 1909, the community had no hospital. He gave it one. . . . When the influenza epidemic hit the city in 1918, he realized the victims needed care around the clock. He gave them that care. . . . When the need for recreational facilities became apparent, he stepped in as one of the prime movers behind a drive that eventually resulted in the development of a golf club, though he seldom had time to enjoy its facilities.

When he became city health officer in 1924 he saw that the children of financially deprived families were going without protective inoculations against disease. He saw to it that they were immunized by pioneering immunization clinics, a practice which later became widespread.

These are but highlights of a 58-year career that was filled with highlights. In a time when general practitioners are becoming a rarity, he represented the epitome of the house-calling country doctor for whom the hour was never too late nor the temperature too cold.

New London realized Dr. Pfeifer's contributions and honored him with a grand celebration in 1959 marking the 50th anniversary of his medical practice, his arrival in New London, and his wedding.

His was a career that savored the joy of life, bringing some 5,000 infants into the world, and anguished in the inevitable sadness of death. Death, which he had witnessed so often, shattered his stamina when his wife of 58 years died on Christmas Day. He suffered a stroke and New London lost its dearest friend six days later.

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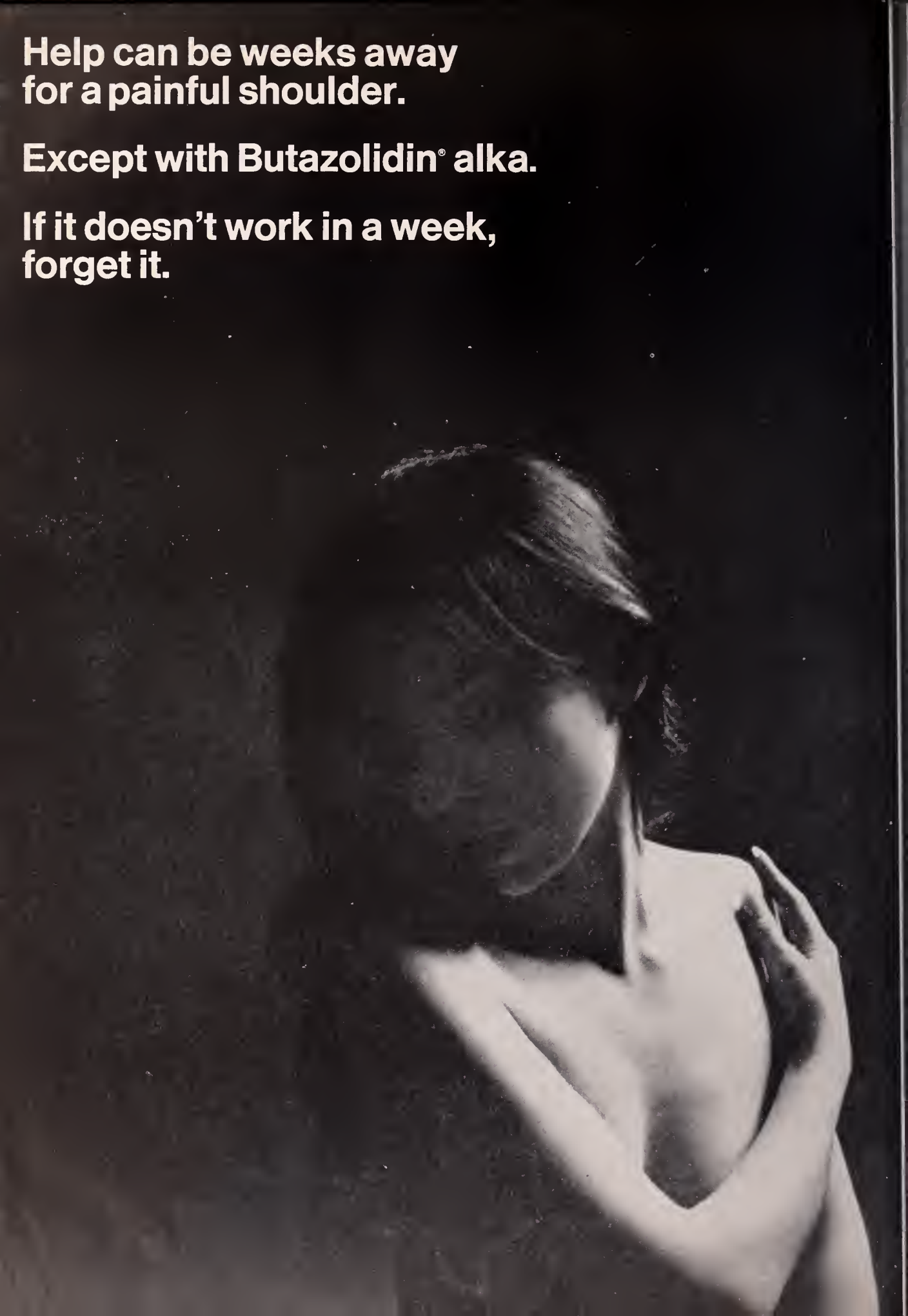

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF JANUARY 15, 1968

NEW MEMBERS

Adamski, Val D., 911 S. Jackson St., Green Bay 54301
Atassi, Safouh A., 134 E. Wisconsin Ave., Neenah 54956
Baker, Ralph K., Box H., Winnebago 54985
Cadwell, Robert E., 400 Strollers Lane, Wausau 54401
Cline, David W., 1300 University Ave., Madison 53706
Crawford, William A., 424 Washington Ave., Oshkosh 54901
Edland, Robert W., 1300 University Ave., Madison 53706
Gammell, Gerald H., Box H., Winnebago 54985
Grieben, Leo R. J., Tri County Mental Health Clinic, Baldwin 54002
Keller, Meredith E., 736 W. 10th Ave., Oshkosh 54901
Maguire, Dennis W., 6130 Century Ave., Apt. 102-D, Middleton 53562
McAndrew, John B., 169 Villa Drive, Neenah, 54956
McGloin, John J., 211 North Commercial, Neenah 54956
McGloin, Mary T., 302 Church St., Neenah 54956
Reilly, G. Douglas, 59 Racine St., Menasha 54952
Ritzenthaler, D. O., 1200 North Center St., Beaver Dam 53916
Rossman, Lawrence J., 400 Strollers Lane, Wausau 54401
Rustia, Ricardo M., 19 S. 3rd St., Winneconne 54986
Stafford, Richard B., Box H, Winnebago 54985
Stelter, Gerald P., 211 North Commercial St., Neenah 54956
Vechinski, Thomas O., Medical Arts Bldg., Wausau 54401
Wegner, Gene P., 4037 Monona Dr., Madison 53716
Zimmerman, Delano E., Box H, Winnebago 54985

CHANGES OF ADDRESS

Abrams, Julian E., Cudahy, to 3940 N. 58th St., Milwaukee 53216
Adam, Alan B., Milwaukee, to 220 Center St., Ridgeway, Pa. 15853
Anderson, A. D., 2665 Marshall Parkway, Madison 53713
Babbitz, Albert L., Milwaukee, to 2200 Deoria Dr., Hallandale, Fla., 33009
Barber, Neil L., Milwaukee, to 29 Delafield Dr., Fort Leonard Wood, Mo., 65473
Beltran, D. J., Wauwatosa, to 2364 Bryant St., Palo Alto, Calif., 94302
Biedlingmaier, Gerald J., Cudahy, to 10456 W. Concordia Ave., Wauwatosa 53222
Bornstein, Samuel L., Oconomowoc, to P. O. Box 549, Hallandale, Fla., 33009
Brown, John F., Oconomowoc, to 10425 W. North Ave., Wauwatosa 53226
Bunke, John W., Waukesha, to 115 Niles Hill Rd., New London, Conn., 06320
Flanary, John R., 10125 W. North Ave., Wauwatosa 53226
Gass, H. I., Racine, to 3607 South Lane, Franksville 53126
Green, Ray E., Brookfield, to 1835 Wisconsin Ave., Sun Prairie 53590
Gunderson, Robert H., 2031 Riverside, Beloit 53511
Haselow, John R., 1416 S. Commercial St., Neenah 54956
Holzgrafe, Robert E., Milwaukee, to W. 226 N. 1509 North Ave., Waukesha 53186
Kelble, John A., 2320 North Lake Dr., Milwaukee 53202
Lucas, George L., Madison, to Qtrs. 594 US Naval Hospital, Memphis, Tenn.
McDuffie, James J., 3660 N. Teutonia Ave., Milwaukee 53206
Mookerjee, Marcus K., 6729 West Capitol Dr., Milwaukee 53216
Motamedi, Naghi, 945 North 12th St., Milwaukee 53233
O'Connor, Robert E., 2727 Marshall Ct., Madison 53705
Pulito, Frank J., Box A, Milwaukee 53226
Rian, Oliver, Green Bay, to 211 N. Third Ave., Sturgeon Bay 54235
Rolfs, T. H., 2469 North 100th St., Milwaukee 53226
Sanford, Leonard L., Hillsboro, to La Farge 54639
Scott, John C., Milwaukee, to 3863 50 ME, Seattle, Wash., 98105
Seelman, J. J., 1616 W. Bendee Rd., Milwaukee 53209
Shahrokh, D. K., 91 South Reserve, Fond du Lac 54935
Smith, Lawrence W., 2021 Washington Ave., Racine 53403
Spicuzza, Salvatore, 6275 Apple Valley, San Antonio, Tex., 78242
Twohig, David J., 232 Cottage Ave., Fond du Lac 54935
Urlakis, Kenneth J., Milwaukee, to 32 Kilsythe Rd., Arlington Heights, Mass., 02175
Varga, Laszlo, 2655 North Grant Blvd., Milwaukee 53210
Wallerius, John F., 3755 South Webster Ave., Green Bay 54301
Weisfeld, Samuel G., 3531 W. Burleigh St., Milwaukee 53215
Wood, Charles F., 1121 48th St. South, Wisconsin Rapids 54494
Zizic, Thomas M., Milwaukee, to 2802 Lasses, Apt. 29, San Antonio, Tex., 78235

REMOVED FROM MEMBERSHIP

Alford, Gary R., Dane County, removed per County Secretary
Balzer, Rudolph R., Milwaukee County, removed per County Secretary
Cherry, James D., Dane County, resigned
Darin, Joseph C., Milwaukee County, removed per County Secretary
Fliegel, Martin B., Dane County, removed per County Secretary
Greenwalt, Tibor J., Milwaukee County, transferred to Washington, D.C.
Morrison, Russell C., Milwaukee County, removed per County Secretary
O'Leary, William J. Sr., Milwaukee County, removed per County Secretary
Rankin, John, Dane County, removed per County Secretary
Schilling, Robert F., Dane County, removed per County Secretary
Wiley, Darrell B., Dane County, removed per County Secretary

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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, cluding a blood count. The patient should r exceed recommended dosage, should be closely supervised and should be warned t discontinue the drug and report immediate fever, sore throat, or mouth lesions (sympto of blood dyscrasia); sudden weight gain (wa retention); skin reactions; black or tarry stoc or other evidence of intestinal hemorrhag occur. Make regular blood counts. Disco tinue the drug immediately and institute countermeasures if the white count chang significantly, granulocytes decrease, or im ture forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of ankles or face may be minimized by with-

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 67, No. 3 MARCH 1968

SCIENTIFIC ARTICLES

Emergency Room Principles in Limb Amputation, by Michael A. Polacek, M.D., F.A.C.S., Thomas Pagedas, M.D. and Edwin Welsh, M.D., Milwaukee ---------- 147

Induction of Ovulation With Clomiphene Citrate, by Paul A. McLeod, M.D., Madison 154

The Use of Clomiphene Citrate (MRL-41; Clomid) for the Induction of Ovulation (Treatment of 81 Patients in 422 Cycles), by William N. Spellacy, M.D., Minneapolis, Minn. ---------- 159

Therapeutic Dilemmas (No. 5 of a series): Mallory–Weiss Syndrome, by Harry Beckman, M.D., Milwaukee ---------- 163

Comments on Treatment: An Approach to Antibiotic Therapy, by Harold D. Rose, M.D., Milwaukee ---------- 168

SPECIAL FEATURES

Effect of Hyperventilation on Precordial T-Waves of Children and Adolescents (abstract) ---------- 158

Carcinoma of the Breast in Children (abstract) ---------- 162

Juvenile Papillomatosis (abstract) ---------- 162

Treatment of Burns With Intensive Therapy and Exposure (abstract) ---------- 167

The 1966 Measles Epidemic Was Dampened If Not Prevented, by H. Grant Skinner, M.D., M.P.H. and William L. Gilbert, B.Sc., Madison ---------- 171

The Wisconsin Regional Medical Program: Operational Projects, by John S. Hirschboeck, M.D., Milwaukee ---------- 181

Wisconsin's Health: State Backs New Tuberculosis Program, by E. H. Jorris, M.D., State Health Officer ---------- 184

127th Annual Meeting Program of the State Medical Society of Wisconsin ---------- 185

EDITORIALS

President's Page: The Corson Report, by Harold J. Kief, M.D., Fond du Lac ---------- 173

Relentless Futility ---------- 175

Postal Abuse ---------- 176

REGULAR FEATURES

Publication Information ---------- 7

Medical Meetings ---------- 22

Letters ---------- 177

The Medical Student Forum ---------- 179

Section on Ophthalmology ---------- 180

State Medical Society ---------- 37

Physician News ---------- 39

County Societies ---------- 53

Specialty Societies ---------- 56

Paramedical/Ancillary ---------- 57

Bookshelf ---------- 64

Physicians Exchange ---------- 66

Index to Advertisers ---------- 68

Wisconsin Physicians Service ---------- 69

Journal
Established 1903

Annual Subscription ----- $10.00
Single Copy ---------- 1.50
Previous Years' ---------- 3.00
January Blue Book ------ 5.00

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ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.

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Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

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Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

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Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

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ABBOTT

MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 WISCONSIN

Apr. 18–19: Conference for Directors of Nursing in Small Hospitals, University Extension, Marshfield.

Apr. 19: Seventh annual cancer conference for nurses: "Nursing Care of the Cancer Patient," Union Theater, Madison UW Campus, UW Division of Clinical Oncology and Wisconsin Division of American Cancer Society.

Apr. 19–20: Annual meeting, Wisconsin Urological Society, Wisconsin Center, Madison.

Apr. 22–24: 98th annual session, Wisconsin State Dental Society, Milwaukee Auditorium, Milwaukee.

Apr. 22–May 3: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

May 9–10: Conference for Directors of Nursing in Small Hospitals, University Extension, Madison.

May 14–16: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 24: Wisconsin Alumni Day, UW, Madison.

June 7–9: Mid-year spring meeting, Wisconsin Society of Pathologists, Eagle Waters Resort, Eagle River.

June 7–9: Thirteenth annual meeting, Wisconsin State Medical Assistants Society, Milwaukee.

Sept. 14–15 (tentative): Fall meeting, Wisconsin Otolaryngological Society.

Sept. 21: Fall meeting, Wisconsin Surgical Society, St. Mary's Hospital, Madison.

Sept. 12–14: Fall meeting, Wisconsin Society of Internal Medicine, Oshkosh, at The Pioneer.

Sept. 14–15: Fall meeting, Wisconsin Society of Anesthesiologists, Lake Geneva, at the Playboy Club.

Sept. 20–22: Fall meeting, Wisconsin Radiological Society, Lake Geneva, at the Playboy Club.

Sept. 25–26: Annual meeting, Wisconsin Academy of General Practice, Pfister Hotel, Milwaukee.

Oct. 8–11: Meeting of the Wisconsin Nurses Association, Sheraton–Schroeder Hotel, Milwaukee.

Oct. 9–10: Meeting of Wisconsin Division, American Cancer Society, Oshkosh.

Nov. 16: Fall annual meeting of Wisconsin Society of Pathologists, Marquette School of Medicine, Milwaukee.

1968 NEIGHBORING STATES

Apr. 17–20: 12th annual postgraduate course on Fractures and Other Trauma, Chicago Committee on Trauma of the American College of Surgeons, John B. Murphy Memorial Auditorium, Chicago, Ill.

Apr. 22–26: "Clinical Endocrinology—Recent Advances in Diagnosis and Treatment," American College of Physicians, Mayo Graduate School of Medicine (University of Minnesota) and Mayo Clinic, Rochester, Minn.

Apr. 23–27: Eighteenth annual meeting, Student American Medical Association, Statler Hilton Hotel, Detroit, Mich.

Apr. 29–May 1: 38th annual Tri-State Hospital Assembly, Palmer House, Chicago, Ill.

May 2–3: Scientific sessions, Illinois Heart Association, Springfield, Ill.

May 2–4: "Prevention in Cardiology," Minnesota Heart Association and the Mayo Clinic, Rochester, Minn.

May 10–11: "Electrophysiology and Electrocardiography," Michigan Heart Association, Detroit, Mich.

June 10–14: "Internal Medicine," American College of Physicians, University of Iowa School of Medicine, Iowa City, Ia.

Sept. 26–29: "The Metabolic Basis of Heart Disease," American College of Physicians, Wayne State University School of Medicine, Detroit, Mich.

Oct. 12–18: Annual Otolaryngologic Assembly of 1968, Illinois Eye and Ear Infirmary at the Medical Center, Chicago, Ill.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

1968 OTHERS

Apr. 17–18: University of Colorado School of Medicine postgraduate course: "Management and Care of Respiratory Insufficiency," Humphreys Postgraduate Center, Denver, Colo.

Apr. 17–19: Postgraduate course: Management and Care of Respiratory Insufficiency, University of Colorado School of Medicine, Denver.

Apr. 21–27: Interamerican Congress of Cardiology, Lima, Peru.

Apr. 22–25: American Industrial Health Conference, Hilton Hotel, San Francisco, Calif.

May 4–9: Annual teaching seminar, International Academy of Proctology, Montreux–Palace Hotel, Montreux, Switzerland.

May 13–17: Annual meeting, Ohio State Medical Association, Cincinnati, the Netherland Hilton Hotel.

May 19–20: First International Symposium on Dextrans, co-sponsored by Texas Heart Association and others, Flagship Hotel, Galveston Island, Tex.

June 17–20: Postgraduate course: Obstetrics and Gynecology, University of Colorado School of Medicine, Stanley Hotel, Estes Park, Colo.

June 19: Joint Session of the American College of Cardiology with the Section of Internal Medicine of the American Medical Association and the American Heart Association, AMA Annual Meeting, San Francisco, Calif.

June 26–28: Summer clinics, Children's Hospital of Denver, Vail, Colo.

July 8–11: Postgraduate course: Ophthalmology, University of Colorado School of Medicine, Stanley Hotel, Estes Park, Colo.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo.

Sept. 28–Oct. 3: Western Hemisphere Congress, International College of Surgeons, Honolulu, Hawaii.

Oct. 6–11: XVI Biennial International Congress, International College of Surgeons, Tokyo, Japan.

Oct. 16–26: Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, International College of Surgeons.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

Oct. 26–Nov. 11: Around-the-World Postgraduate Clinics, International College of Surgeons, India, Egypt, Holy Land, Israel, and Greece.

Nov. 13–16: Forty-seventh annual convention, National Easter Seal Society for Crippled Children and Adults, Sheraton-Boston Hotel, Boston, Mass.

Nov. 19–20: 22nd Annual Meeting, American Heart Association Council on Arteriosclerosis, Bal Harbour, Fla.

Nov. 20–22: Sixtieth annual conference, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Nov. 21–24: 41st Scientific Sessions, American Heart Association, Bal Harbour, Fla.

Nov. 25–26: Annual Assembly Meeting, American Heart Association, Bal Harbour, Fla.

1969 OTHERS

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

1968 AMA

June 16–20: 117th Annual Convention, San Francisco, Calif.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Course on Respiratory Insufficiency, Colorado

The University of Colorado School of Medicine announces a three-day postgraduate course on MANAGEMENT AND CARE OF RESPIRATORY INSUFFICIENCY, to be held in Denver, Colo., April 17–19. This is an intensive consideration of the principles and techniques of care for patients with moderate or severe respiratory distress. Methods of rehabilitation and continued care are also featured.

This course stresses the team approach and nurses working in respiratory care are encouraged to attend with their physician. For nurses who accompany their physician to the course, a two-day review of lung anatomy and physiology is offered by the University of Colorado School of Nursing immediately preceding this course (April 15 and 16).

The tuition fee is $75.00 for physicians for the three days, and $75.00 for nurses for the five days. For further information and a detailed program, write to: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

Student American Medical Association Meeting

The eighteenth annual meeting of the Student American Medical Association is scheduled for the Statler Hilton hotel, Detroit, April 23–27. The 1968 meeting is being held in the Motor City as a feature of the Centennial celebration of Wayne State University and its School of Medicine. David A. Kindig, University of Chicago senior and National SAMA President, is serving as General Chairman.

The 1968 meeting will see several score resolutions on as many subjects presented to the House of Delegates, official deliberative body of SAMA representing 82 chapter schools. Standing and ad hoc committee reports, as well as the initial report from the SAMA Evaluation Commission will occupy many hours of delegate time.

Concurrent with the SAMA meeting will be the 11th Annual Meeting of the Woman's Auxiliary to SAMA, presided over by National WA–SAMA President, Mrs. Norman R. Nedde, San Francisco.

One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
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and protects intestinal mucosa.

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(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

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International Symposium on Dextrans, Texas

The first Internationl Symposium on Dextrans will be held at Galveston Island, Tex., on Sunday and Monday, May 19 and 20. Entitled CURRENT CONCEPTS OF THE BASIC ACTIONS OF DEXTRANS AND THEIR CLINICAL APPLICATION IN THE CARDIOVASCULAR AND RELATED FIELDS, the symposium is co-sponsored by the Texas Heart Association, the Council on Circulation of the American Heart Association, the Postgraduate Education Division of the University of Texas Medical Branch, the University of Minnesota Medical School, and the Georgia Institute of Technology-Biomedical Division.

Researchers from Europe and the United States who have carried out extensive research studies on the Dextrans for 20 years or more will participate in this important two-day symposium. Program planners advise that the major emphasis of the symposium will be placed on the use of Dextrans in the cardiovascular field.

Programs, advance registration, and hotel reservation forms for the Dextran Symposium may be obtained by writing or calling the Texas Heart Association, P.O. Box 25041, Houston, Tex. 77005; Area Code 713-JAckson 6–4194.

Course on Obstetrics and Gynecology, Colorado

The University of Colorado School of Medicine announces a four-day postgraduate course in OBSTETRICS AND GYNECOLOGY, to be held at the Stanley Hotel in Estes Park, Colorado June 17–20. This course is designed primarily for the obstetrician–gynecologist and topics to be presented include fetal distress, uterine dysfunction, treatment of ovarian carcinoma, chemotherapy, management of ovarian masses, and the role of radical surgery for gynecological malignancies.

Three eminent guest speakers will participate: Louis M. Hellman, M.D., Brooklyn, N. Y.; Charles A. Hunter, M.D., Seattle, Wash.; and Richard F. Mattingly, M.D., Milwaukee, Wis.

Tuition and registration fees are $80.00. For further information and a detailed program, write to: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

Course on Ophthalmology, Colorado

The University of Colorado School of Medicine in cooperation with the Colorado Ophthalmological Society will present a postgraduate medical education course on Ophthalmology July 8–11 at The Stanley Hotel, Estes Park, Colo. The course will be held in conjunction with the summer convention of the Colorado Ophthalmological Society. There will be four outstanding guest speakers: Robert P. Burns, M.D., Portland, Ore.; Philip Knapp, M.D., New York, N. Y.; Harvey A. Lincoff, M.D., New York, N. Y.; and J. Donald Gass, M.D., Miami, Fla.

Tuition for the four days: $80. Detailed program available May 1. Contact: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

Easter Seal Convention in Boston

The forty-seventh annual convention of the National Easter Seal Society for Crippled Children and Adults will be held in Boston, Mass., Nov. 13–16. Sessions will be held in the Sheraton–Boston Hotel. Leon Chatelain, Jr., Washington, D. C., president of the National Society, will preside. Thomas Teas, Mason City, Ia., is convention chairman. Further details: Sumner G. Whittier, Executive Director, 2023 West Ogden Ave., Chicago, Ill. 60612.

National Conference, Prevention of Blindness

In special commemoration of the Society's 60th anniversary, the National Society for the Prevention of Blindness will hold its 1968 annual convention Wednesday, Thursday, and Friday, November 20–22, at the Roosevelt Hotel, in New York City.

The three-day conference will coincide with the Society's annual membership and board of directors' meetings, scheduled for November 21 at the Roosevelt Hotel.

About 400 professional and volunteer workers in the prevention-of-blindness field are expected to attend. More details will be published later.

Pediatric Summer Clinics, Colorado

Children's Hospital, Denver, is holding its Summer Clinics at Vail on June 26, 27, and 28. Guest Faculty: Virginia Apgar, M.D., M.P.H., The National Foundation; Louis K. Diamond, M.D., Harvard University; Robert G. Frazier, M.D., The American Academy of Pediatrics; Harry Medovy, M.D., F.R.C.P.(C), University of Manitoba; Paul Wehrle, M.D., University of Southern California. Morning seminars and lectures. Afternoons of leisure in the Rocky Mountains.

FEE $40.00. Guest reservations will be accepted in order of receipt of registration fee. Registration will be limited. WRITE: Department of Continuing Education, Children's Hospital, Nineteenth Avenue at Downing, Denver, Colo. 80218.

Wisconsin Urological Society

The annual meeting of the Wisconsin Urological Society will be held at the Wisconsin Center, 702 Langdon Street, Madison, April 19 and 20. The visiting guest speaker will be Dr. John Grayhack, Chief of Urology at the Northwestern University Medical School. The meeting is open to all interested physicians. For further information contact John B. Wear, Jr., M.D., Secretary–Treasurer, WUS, 1300 University Ave., Madison, Wis. 53706.

State Medical Society Annual Meeting

See complete program in this issue starting at page 185.

SESSIONS ON AUTO ACCIDENTS, HEALTH CARE PLANNING AMONG PROGRAMS AT AMA ANNUAL CONVENTION

Four general scientific meetings of wide medical interest will be included in the Scientific Program of the American Medical Association's 117th Annual Convention to be held in San Francisco June 16–20.

The four general sessions:

—Automobile Accidents, with participation by Sections on Orthopedic Surgery, General Surgery, Pediatrics, Physical Medicine, and Preventive Medicine, as well as the AMA Committee on Medical Aspects of Automotive Safety.

—Health Care Planning, with participation by Sections on Preventive Medicine, Diseases of the Chest, General Practice, General Surgery, Internal Medicine, and Military Medicine.

—Management of Infectious Diseases, with participation by Sections on Experimental Medicine and Therapeutics, Allergy, Diseases of the Chest, General Surgery, Pediatrics, and Preventive Medicine.

—Treatment of Advanced Malignant Disease, with participation by Sections on General Surgery, Gastroenterology, General Practice, Internal Medicine, Nervous and Mental Diseases, Pathology and Physiology, Colon and Rectal Surgery (formerly Proctology), and Radiology.

Regular scientific programs also will be presented by each of the 22 Scientific Sections, plus a program by the Section on Miscellaneous Topics. The latter program will include a full day session on smoking and health sponsored by the AMA Committee on Research for Tobacco and Health, and a full day session on neurological surgery in which the American Association of Neurological Surgeons will participate.

The entire scientific program will appear in the May 6 issue of the Journal of the American Medical Association.

The youngest exhibitors and official guests of the AMA and its Annual Convention will be two teenage high school scientists.

They will be chosen at the 19th International Science Fair in Detroit May 15–18 by members of the AMA Council on Scientific Assembly. Competing with over 400 other finalists from every state and several foreign nations, the two top AMA winners will be named for the excellence of their studies and exhibits in the basic medical sciences.

During the Convention, they will exhibit their displays in the Scientific Exhibit and will be introduced as honored guests of the AMA to the House of Delegates, the Woman's Auxiliary to the AMA, and at the Scientific Awards Dinner.

The AMA has been participating in the International Science Fair for 13 years as part of its program to attract superior students to the study of the medical and health sciences.

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State Medical Society Mails 47,000 Open Panels

In January, nearly 46,000 Open Panels were distributed by the State Medical Society to all employers subject to the Workmen's Compensation Act in Wisconsin, including those outside the state who file reports to the Workmen's Compensation Division of the State Department of Industry, Labor and Human Relations. Since the initial mailing there have been over 1,000 requests for additional panels.

The State Medical Society of Wisconsin and the Workmen's Compensation insurance carriers have for many years subscribed to the principles of the Open Panel, wherein any member of the State Medical Society who so expresses a desire may have his name, office address, and office telephone listed on panels prepared on a county basis and distributed to employers covered by the Workmen's Compensation Act.

Under Wisconsin law, all employers of three or more persons are required to provide their employes with reasonable choice for physicians in case of accident or illness resulting from their occupation.

Periodically the State Medical Society revises and prints a new listing of Open Panels. In the latest revision 4,073 physicians were contacted as to whether they wished to be listed on the Open Panels. Of this total, 2,009 accepted and were listed on the various county panels, 1,888 indicated they did not want to be listed, and 176 did not reply. Some physicians, because of their specialties, are not particularly inclined to treat any and all kinds of Workmen's Compensation cases.

In addition to the physician listing, the Open Panels include a list of insurance companies agreeing to participate in the program. Each company licensed to sell Workmen's Compensation insurance in Wisconsin also was contacted by the State Medical Society as to whether the company would participate in the Open Panel program. Of the 185 companies contacted, 72 agreed to participate and were included in the latest printing. Most of the companies not participating do not actively sell this type of insurance in Wisconsin.

To be listed on the Open Panels carries with it certain obligations, and likewise on the part of the insurance carrier there are certain obligations in reference to physician relationships. Discussion of the Open Panel Program appeared in the January 1968 issue of the *Wisconsin Medical Journal*, at page 20, in the article: "What Every Doctor Should Know About Workmen's Compensation."

FILM: CAREER OPPORTUNITIES

A new film depicting the wide range of rewarding career opportunities existing in fields allied to medicine, long sought by auxiliaries and others concerned with health careers programming, is available.

The 28-minute color film, entitled "Horizons Unlimited," after the AMA's health careers handbook of the same name, gives brief on-the-job glimpses of men and women serving in career pursuits highlighted in the publication. To give viewers greater insight as to the length of preparation and particular scope of specific professions and occupations, "thought voices" are utilized in some segments of the film.

The University of Kansas Medical Center, Kansas City, served as the setting for the film, which will replace the time-dated film, *Helping Hands For Julie*, developed by the AMA in cooperation with E. R. Squibb & Sons, in 1959.

The new film was developed solely by the AMA. Physicians, medical societies and other medical groups should place their orders for showings, stating preferred and alternate dates, with the Films Section, AMA, 535 North Dearborn, Chicago, Ill. 60610. Schools and other nonmedical groups should direct their requests for loan of the film to Modern Talking Pictures, Prudential Plaza, Chicago, Ill. 60601.

* * *

ORAL CANCER—A new American Cancer Society film expressly for physicians and medical students. It presents a visual and digital oral examination to be given as a part of a routine physical checkup for asymptomatic patients. To arrange screening of this 22 minute film, call your local ACS.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY HOME DURING THE MONTH OF FEBRUARY 1968

1 Cardiology Study Committee, Wisconsin Regional Medical Program
5 Madison Academy of Internal Medicine
6 Board of Trustees, Dane County Medical Society
6 Madison Urological Society
6 Madison Anesthesiology Society
9 University Hospitals Interns and Wives
14 SMS Commission on Safe Transportation
15 SMS Commission on Hospital Relations and Medical Education
19 Stroke Study Committee, Wisconsin Regional Medical Program
21 University of Wisconsin "In-Depth" Scientific Program
22 Wisconsin Clinic Managers
24 Association of State Universities Student Health Service
27 Inter-Hospital Coordinating Disaster Committee

Meetings not held in the Society Home but which have a direct relationship are printed in italics, with the location in parentheses.

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and only a physician—only a professional diagnosis—can establish the etiology for a given patient. Then, if Conditioned Response Therapy is indicated, an Enuresis Alarm is best used under the physician's guidance. This is why S & L Enuresis Alarms are rented to patients **on prescription only.** S & L is the only nation-wide alarm rental service whch restricts itself to **prescription** rentals.

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Physicians are supplied with convenient prescription forms for this particular purpose. We also provide a reprint of the report, "Management of Nocturnal Enuresis by Conditioned Response", from the Journal of the A.M.A., as an aid in supervising this treatment.

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PHYSICIAN NEWS

Doctor Waisbren Awarded Wyeth Grant

Dr. Burton A. Waisbren, associate clinical professor of medicine at Marquette School of Medicine and director of the infectious disease service at Milwaukee County General Hospital, in January received a $3,000 unrestricted grant for medical research from Wyeth Laboratories.

Wyeth Laboratories yearly presents a limited number of unrestricted grants for medical research to leading U. S. medical schools and hospitals, with the expressed purpose of adding latitude and flexibility to research programs. Most grants awarded for specific projects require detailed advance description of a project as well as a follow-up report. The Wyeth awards do not obligate the recipient in any way.

Dr. Holzman Joins Counseling Center

Dr. Bruce R. Holzman in January joined the Counseling Center of Sauk, Juneau and Richland counties. He is at the Center one day per week in the Psychiatric Residency Program of Community Psychiatry. Doctor Holzman resides in Madison. He received his medical training at Northwestern University and served his internship at Cook County Hospital. Currently he is a resident at the University of Wisconsin and has started a Child Psychiatry Fellowship. He will be working closely with *Dr. Rudolf W. Link* who is the Medical Director and Chief Psychiatrist of the Counseling Center.

St. Joseph's Medical Staff Named

The annual meeting of the St. Joseph's Hospital Medical Staff was held January 16 at the hospital. During the program *Dr. Thomas J. Rice* introduced the newly elected members of the executive staff. They are: *Dr. George L. River* replacing Dr. Thomas J. Rice as chief-of-staff; Dr. Warren J. Holtey replacing *Dr. Gerald Porter* as vice-chief-of-staff; *Dr. Dayton H. Hinke* replacing Doctor River as secretary and Doctor Rice and *Dr. Joseph L. Ousley* replacing *Dr. Robert Heywood* and *Dr. Donald Pederson* as members-at-large.

Gundersen Clinic Increases Staff

Two internists, a neurosurgeon and an eye specialist, recently were appointed to the staff of the Gundersen Clinic in La Crosse. They are: *Dr. Rudolph Keimowitz*, who graduated from the University of Vermont, served a combination medical–surgical internship at the Upstate Medical Center in Syracuse, N.Y., plus a year as assistant resident in medicine, was senior assistant resident in medicine on the Boston University service at Boston City Hospital, served as clinical fellow in hematology for the Tufts University Service, and served in the Army in 1966–67; *Dr. Kermit Newcomer*, who graduated from Western Reserve University, Cleveland, served his internship and residency at Walter Reed General Hospital, Washington, D.C., spent three years with U.S. armed forces in Germany and was chief of general medical service at Fitzsimmons Army Hospital in Denver; Dr. Carl Belber, who received his M.D. from the University of Pennsylvania, did residency work in neurosurgery at the University of Oregon for five years, and was one of three neurosurgeons in Germany for the Army before joining the Clinic; and *Dr. Joseph Wahl*, who graduated from the University of Tennessee, interned at Naval Hospital in San Diego, was a Navy flight surgeon for two years, and obtained his residency in Ophthalmology at the University of Colorado Medical Center. Doctor Wahl was in private practice for three years before joining the clinic.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Mohs Heads Chemosurgery Group

Dr. Frederic E. Mohs, associate clinical professor of surgery, UW Medical Center, has been elected first president of the American College of Chemosurgery which had its organizational meeting in Chicago Dec. 5. According to Doctor Mohs, the College was organized to provide a means of accrediting physicians who use chemosurgery, to safeguard the standards of chemosurgery, to provide a means for the exchange of ideas, and to educate both physicians and the public about the specialty. Chemosurgery was developed at the UW Medical Center and has been used there for about 31 years.

Dr. Cameron Heads Physicists

John Cameron, PhD, professor of radiology and physics, was installed Dec. 1 as president of the American Association of Physicists in Medicine. This is the only association for medical physicists in the United States.

Dr. Larson Honored at Hospital

Dr. Duane L. Larson, formerly of Stoughton and a graduate of the University of Wisconsin Medical School, has received a commendation ribbon with pendant awarded to him by the United States Army Medical Corps for research in the field of thermal injuries. Doctor Larson is the chief surgeon at the Shriners' Burn Institute, Galveston, Tex., which opened in 1966 for the treatment of severe burns of children.

Dr. Senty Elected President of Staff

Dr. Robert M. Senty, Sheboygan, recently was elected president of the St. Nicholas Hospital staff in Sheboygan. He succeeds *Dr. Harold N. Heinz.*

Milwaukee Pediatrician Featured

Dr. Elaine Kohler, a pediatrician working under a government grant on metabolic diseases at Milwaukee Children's Hospital, was featured recently in the MILWAUKEE JOURNAL.

St. Francis Hospital Elects Dr. Chojnacki

Dr. Steve L. Chojnacki, Milwaukee, has been elected president-elect of the St. Francis Hospital medical staff. He will take office as chief-of-staff in two years.

Elevated to chief-of-staff is *Dr. Louis B. Uszler*, Milwaukee, who succeeds *Dr. Theodore P. Borowski*, Milwaukee.

Dr. John A. Malone, Milwaukee, was reelected secretary–treasurer.

Dr. Reznichek Serves in Vietnam

Dr. Richard C. Reznichek, a native of Madison, is serving in South Vietnam for two months with the American Medical Association's Volunteer Physicians for Vietnam program. Doctor Reznichek, son of *Dr.* and Mrs. *Cyrus G. Reznichek* of Madison, is a graduate of the University of Wisconsin and received his medical degree from Northwestern University School of Medicine. He is currently a resident in urology at Harbor General Hospital, Torrance, Calif.

Platteville Medical Center Completed

Doctors Park, a medical center which is complete as one unit but yet separately arranged to allow individual practices by a group of doctors, has been completed at Platteville. Three physicians own the facility under the title "Associated Physicians of Platteville." They are *Drs. C. L. Steidinger, M. F. Steussy*, and *Stanley J. Nuland.*

Dr. C. F. Broderick Guest Speaker

Dr. C. F. Broderick, Wisconsin Dells, recently spoke on the physical and medical aspects of sex before a group of high school students.

Dr. Huibregtse Elected President

Dr. Willard G. Huibregtse, Sheboygan, recently was elected president of the Sheboygan Memorial Hospital medical staff. Other officers elected are: *Drs. Henry Winsauer*, vice-president, and *Earl H. Jochimsen*, secretary-treasurer.

Dr. Hirschboeck Speaker for Service Clubs

Dr. John S. Hirschboeck, Milwaukee, 1968 chairman of the Wisconsin Heart Fund drive and coordinator for the Wisconsin Regional Medical Program, recently was the guest speaker before the Manitowoc service clubs. Doctor Hirschboeck discussed modern research in the cardiovascular field, including the recent and nearly spectacularly successful heart transplant by a surgical team in South Africa.

Dr. Hickey Heads Hospital Staff

Dr. A. W. Hickey, La Crosse, recently was elected president of the medical staff at St. Francis Hospital in La Crosse. Other officers elected were: *Drs. John T. Skemp*, president-elect, and *Paul J. Meis*, secretary-treasurer.

Dr. Kabler Appointed Chief Guard Surgeon

Dr. J. D. Kabler, Madison, University of Wisconsin medical school professor, recently was appointed chief surgeon of the Wisconsin National Guard. He will direct the efforts of three separate medical units. Doctor Kabler is a veteran of 23 years of military service and holds the rank of colonel.

Dr. Dernlan Joins Staff

Dr. Robert L. Dernlan, Wauseon, Ohio, recently joined the staff of the Manitowoc Clinic. Before joining the clinic, Doctor Dernlan was assistant chief of surgery at the U.S.P.H.S. Hospital at Baltimore, Md., deputy chief of surgery at U.S.P.H.S. Hospital at Seattle, Wash., and in private practice at Wauseon, Ohio.

Dr. Bjurstrom Guest Speaker

Dr. Robert O. Bjurstrom, Eau Claire, recently was the guest speaker before the Kiwanis Club in Eau Claire. Doctor Bjurstrom's speech was entitled "Feeling No Pain."

Dr. Balistrieri Serves Ozaukee Clinic

Dr. James J. Balistrieri, director of adolescent psychiatric services for Milwaukee County General Hospital, will serve as part-time medical director of the Ozaukee County Mental Health Clinic at Port Washington. He is replacing Dr. Richard Vodegel who recently resigned to devote more time to private practice.

Dr. Treffert Guest Speaker

Dr. Darold W. Treffert, superintendent of Winnebago State Hospital, recently spoke before the Waukesha County Association for Mental Health. The title of Doctor Treffert's speech was "Mental Illness —Can It Be Prevented?"

Dr. Land Named Chief-of-Staff

Dr. James F. Land, Madison, recently was elected chief-of-staff of Madison General Hospital. Other officers include *Drs. James F. McIntosh*, vice-chief-of-staff; *Paul L. Davidson*, secretary-treasurer; and *Charles A. Doehlert, Jr.*, representative to the Dane County Medical Society.

Dr. Healy Joins Clinic

Dr. William G. Healy, Madison, has accepted a position with the Pember–Nuzum Clinic in Janesville. Doctor Healy recently completed a three-year residency in the field of psychiatry at the University of Iowa and at the National Mental Health Institute. Doctor Healy graduated from the University of Wisconsin Medical School in 1943.

Dr. Gottschalk Joins Marshfield Clinic

Dr. Paul Gottschalk recently joined the staff of the Marshfield Clinic. Doctor Gottschalk graduated from the University of Illinois in 1960 and com-

pleted his internship at the naval hospital in Portsmouth. Doctor Gottschalk was a flight surgeon in the Navy Medical Corps for three years, and after his discharge he served a residency at the Mayo Clinic, Rochester, Minn., for four years.

Wauwatosa Doctors Elected at West Allis

Dr. James V. Pilliod, Wauwatosa, recently was elected chief-of-staff at West Allis Memorial Hospital. Others elected are: *Drs. Henry Twelmeyer,* chief of surgery; *Delbert Miner,* chief of general practice; *William Baird,* chief of obstetrics; and *DeLore Williams,* Milwaukee, chief of medicine.

Dr. Arnold Heads Medical Staff

Dr. William Arnold recently was elected president of the medical staff of the Clintonville Community Hospital. Dr. Irving Auld was elected secretary-treasurer.

Dr. Janis Joins Clinic

Dr. John F. Janis recently joined the Gundersen Clinic and La Crosse Lutheran Hospital. Doctor Janis graduated from the Marquette University School of Medicine in 1959. Following his internship at Sacred Heart Hospital, Yankton, S.D., he served a four-year fellowship at the Mayo Clinic, Rochester, Minn. Doctor Janis spent two years in the United States Army where he was chief of laboratory service at McDonald Army Hospital, Fort Eustis, Va. After his release from service, he returned to the Mayo Clinic for a one-year fellowship before coming to La Crosse.

Dr. Curreri Guest Speaker

Dr. Anthony R. Curreri, Madison, chairman of the Department of Surgery at University Hospitals, recently was the guest speaker at a luncheon meeting of Temple Beth El Sisterhood. Doctor Curreri's speech was entitled "A Doctor's View of Vietnam." He is mobilization designee in surgery to the United States Surgeon General.

Dr. Wessels Joins Cantwell–Peterson Clinic

Dr. Dennis H. Wessels recently joined the medical staff of the Cantwell–Peterson Clinic in Janesville. Doctor Wessels graduated from the University of Iowa Medical School and for the past three years has been a naval flight surgeon at Cheery Point, N. C .

Dr. Job Joins Medical Center

Dr. Edward Job, Chicago, recently joined the staff of the Janesville Medical Center. Doctor Job graduated from the Stritch School of Medicine, Loyola University, and his internship and residency were taken at St. Joseph's Hospital, Chicago. He served with the United States Army Air Force Hospital at Sawyer Air Force Base, Mich., and recently was certified with the board of obstetrics and gynecology.

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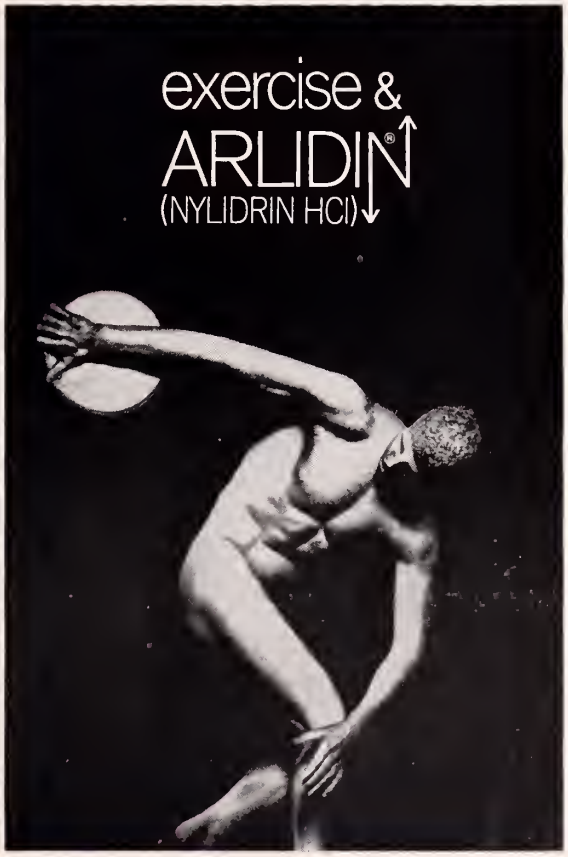

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PHYSICIAN NEWS *continued*

Officers and Directors Named for Marshfield Clinic

Dr. James Manier and Dr. D. T. Fullerton recently were elected to three-year terms at a meeting of the Marshfield Clinic Foundation for Medical Research and Education. *Dr. Dean A. Emanuel*, vice-president of the Foundation the past year, was elected president and Doctor Fullerton was elected vice-president; and *Dr. T. F. Nikolai* was reelected secretary. Other members of the board include, *Drs. R. D. Sautter*, D. A. Tewkesbury, *L. L. Schloesser*, G. E. Porter, *T. G. Olsen* and *W. F. Schorr. Dr. R. F. Lewis*, president of the Clinic, is an ex-officio board member.

Dr. Nichol Joins Clinic

Dr. Katherine P. Nichol, Madison, recently joined the pediatrics department of Associated Physicians. Doctor Nichol graduated from the University of Wisconsin Medical School in 1962. She served her internship at Madison General Hospital and followed that with a one-year pediatric residency at Milwaukee Children's Hospital and a year at University Hospitals. Before joining Associated Physicians, she had been on a post-doctoral fellowship in infectious diseases.

Dr. Gottlieb Accepts New Position

Dr. Abraham M. Gottlieb, director of the VA Hospital in Madison, recently accepted the position of director of the Veterans Administration Hospital in Palo Alto, Calif. Doctor Gottlieb graduated from the University of Illinois College of Medicine in 1933. He entered VA service at the Hines, Ill., VA Hospital in 1937 and served at Tuscaloosa, Ala., and Wood, Wis. In 1942 he was attached to the Army Medical Corps where he attained the rank of lieutenant colonel. In 1946 Doctor Gottlieb was assigned to Dearborn, Mich., where he served first as chief of the Cardiology Section and then as chief-of-staff. Doctor Gottlieb has been with the VA Hospital in Madison since 1959.

Dr. Banyai Elected Honorary Member

Dr. Andrew L. Banyai, Chicago, Ill., clinical professor of medicine, emeritus, Marquette School of Medicine, was elected an honorary member of the Argentine Association for the Advancement of Internal Medicine and of the Society of Internal Medicine of Buenos Aires, Argentina.

Dr. Potter Serves in Dominican Republic

Dr. G. L. Potter, Neenah, recently spent a month in the Dominican Republic as a volunteer specialist with MEDICO, a service of CARE. Doctor Potter graduated from McGill University in 1955 and served as a medical missionary for three years in Humacao, Puerto Rico, and completed his residency at Northwestern University, Chicago, in 1964.

Dr. Irwin Named Chief-of-Staff

Dr. Wallace Irwin, Lodi, recently was elected chief-of-staff at Divine Savior Hospital. *Drs. T. S. Westcott,* Pardeeville, was elected vice-president and *Stewart F. Taylor,* Portage, secretary-treasurer. Doctor Irwin has been a member of the medical staff since 1947. He succeeds *Dr. F. W. Gissal,* Wisconsin Dells, who has served as chief-of-staff for the past three years.

Dr. Myers Guest Speaker

Dr. Robert E. Myers, Two Rivers, recently was the guest speaker before a meeting of the 12th district Wisconsin Nurses' Association. His topic was on "An Approach to Sex Education."

Dr. Weygandt Named to Committee

Dr. James L. Weygandt, Sheboygan Falls, recently was appointed to the newly-created advisory committee on state highway safety. Doctor Weygandt is chairman of the State Medical Society's Commission on Safe Transportation.

Dr. Chandler Earns Certificate of Merit

Dr. William W. Chandler, Appleton, recently was presented a Certificate of Merit from the Outagamie County Cancer Society Unit. Doctor Chandler has served 10 years on the cancer society's board of directors.

Dr. Hoessel Elected Officer

Dr. A. W. Hoessel, Wausau, recently took office as a first vice-president at the 56th annual dinner meeting of the Wausau Area Chamber of Commerce. Doctor Hoessel is also president-elect of the Marathon County Medical Society.

Chilton Doctors Share Award

Drs. Kenneth R. Humke and *James W. Knauf,* Chilton, recently shared the honors of the "Man of the Year" awards at the honors event sponsored by the Chamber of Commerce. Both doctors are members of the Calumet Memorial Hospital Medical staff and are past chiefs-of-staff of the hospital. Doctor Knauf is also on the associate staff of St. Elizabeth's Hospital, Appleton.

Dr. Dega Guest Speaker

Dr. Francis J. Dega, Green Bay, recently was the guest speaker at a session which kicked off activities for National Heart Month. The discussion was sponsored by the Wisconsin Heart Association's Brown County Heart Committee.

Dr. Lokvam Guest Speaker

Dr. Leif H. Lokvam, Kenosha, recently spoke on his experiences in Vietnam before the Lutheran Church congregation at its dinner meeting held in Kenosha.

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PHYSICIAN NEWS *continued*

Dr. Krapohl New Staff Member

Dr. Andrew J. Krapohl, Marinette, recently joined the staff of the Marinette Medical Clinic. He graduated from the University of Michigan School of Medicine in 1959 and had been an instructor in the medical school of the University of Nebraska until moving to Marinette.

Dr. Reed Serves on Executive Committee

At the recent 24th annual meeting of the American Academy of Allergy held in Boston, Mass., *Dr. Charles E. Reed,* Madison, was elected to serve on the Executive Committee of the Academy.

Dr. Weatherhogg Guest Speaker

Dr. Curtis Weatherhogg, Madison, consultant with the Dane County Family Life Clinic, recently spoke before the Parent-Teachers Association at Hawthorne School. Doctor Weatherhogg spoke on the emotional and physical development of a child.

Memorial Hospital Adds Six to Staff

Memorial Hospital of Oconomowoc recently added six new members to its staff. They are: *Drs. Maurice Greenberg, Ronald W. Stein, S. M. Doubrava, Robert B. Dawes,* Irwin F. Hoeft, and A. M. Kelchner.

Drs. Gutmann and Betlach Head Medical Staff

Dr. George E. Gutmann, Janesville, recently was elected chief-of-staff of the Mercy Hospital and *Dr. Eugene H. Betlach* was named president. *Dr. Donald Knepel* was elected secretary. Prior to coming to Janesville in 1948, Doctor Gutmann did postgraduate work at the Medical College of Virginia in Richmond, Peter Bent Brigham Hospital and Beth Israel Hospital, Boston, Harvard Medical School and Milwaukee County Hospital. He is a charter member of the Wisconsin Society of Internal Medicine and was its president in 1964–65. Doctor Gutmann was elected a fellow in the American College of Physicians in 1957. Doctor Betlach has been associated with Mercy Hospital since 1953. He graduated from the University of Wisconsin Medical School and served as flight surgeon in the Air Force for two years. Doctor Betlach received the degree of fellow in the American College of Radiology and has been certified by the American Board of Radiology. He is a former president of the Wisconsin Radiological Society.

Dr. Telford Announces Partnership

Dr. John Telford, chief-of-staff of the Washburn Hospital, recently announced his partnership with Dr. Ralph Tharp. Doctor Tharp graduated from the University of Minnesota in 1966 and interned in Des Moines, Iowa. He came to Washburn from Lebanon, Ore., where he was practicing medicine while associated with a clinic.

Dr. Sannes Given Testimonial Dinner

Dr. W. A. Sannes, Soldiers Grove, recently was given a testimonial dinner honoring him for his 35 years of service to the community. Doctor Sannes came to this country from Norway at the age of 12, graduated from the University of Wisconsin and received his doctor's degree from the University of Cincinnati in 1930. He interned at Madison General Hospital and set up his practice in Soldiers Grove.

Dr. Lawrence Guest Speaker

Dr. David L. Lawrence, Fond du Lac, recently was the guest speaker before the PTA in Campbellsport. Doctor Lawrence spoke on "How We, As Parents, Can Teach Our Own Children Sex Education at Home."

Dr. Dietsch Retires After 41 Years

Dr. L. C. Dietsch, Plymouth, recently retired from active practice after 41 years of service to the community. Born and raised in Plymouth, he graduated from the University of Wisconsin and then went on to receive his medical degree from Rush Medical College, Chicago. He interned at Evanston Hospital. Doctor Dietsch spent one year of practice in Rice Lake and then returned to Plymouth.

Guest Speakers at Clinical Session

Dr. Stanley Graven, director of the Hartford Neonatal Center at St. Mary's Hospital in Madison and assistant professor of pediatrics at the University of Wisconsin Medical School, and his associate, Dr. Gerald Staub, recently were the principal speakers at a clinical session on the "Infant Intensive Care Center." The session was sponsored by the Madison District Nurses' Association.

Dr. Stahmer Appointed to Finance Committee

Dr. A. H. Stahmer, Wausau, recently was appointed to a one-year term on the finance committee of the American Academy of General Practice.

Dr. McRoberts Appointed Deputy CD Medical Director

Dr. Jerry W. McRoberts, Sheboygan, recently was appointed deputy civil defense medical director in Sheboygan County. Doctor McRoberts will serve as advisor and assistant to *Dr. Richard B. Windsor* who succeeded Doctor McRoberts as county medical director last June.

Dr. Ovitt Heads Hospital Staff

Dr. David Ovitt, Milwaukee, recently was reelected to a two-year term as president of the medical staff at St. Mary's Hospital, Milwaukee. Reelected vice-president and secretary-treasurer respectively were *Drs. Anthony J. Sanfelippo* and *John P. Schelble*. Chairmen serving their first-year terms are: *Drs. William C. Fetherston*, obstetrics and gynecology; *Carl G. Dunst*, general practice; and *Larry J. Polacheck*, pediatrics.

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1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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Doctors Reelected to Academy

The following Doctors recently were reelected to active membership in the American Academy of General Practice. They are: *Drs. Lorne A. Campbell, Jr.*, Clear Lake; *David A. Cohen*, Edgerton; Wolfgang Dietsche, Wisconsin Rapids; *Thomas F. Heighway*, Middleton; *Martin H. Sahs*, Hayward; *D. J. Welter*, Shell Lake; *Harry E. Schaefer*, and *Theodore A. Teitgen*, Manitowoc; *Andrew Lucas*, Wisconsin Rapids; *John H. Steiner*, Waupaca; *Robert M. Anderson*, Cumberland; *Ward E. Brown*, *John L. Buhl*, *Thomas E. Dugan*, and *John E. Promer*, Waukesha; *Lloyd S. Kellogg*, Oregon; *Rocco S. Galgano*, Delavan; *W. E. Myers*, Fond du Lac; *Robert E. Urbanek*, Beaver Dam; *Marvin H. Olson*, Schofield; *Jack D. Brown*, Sparta; *Thomas E. Boston*, Hillsboro; *Chester W. Crawford*, *John E. Dettmann*, *Bernard Kulkowski*, and *Henry Carl Rahr*, Green Bay; *Charles L. Steidinger*, Platteville; Dean M. Ericksen and Fred Burnett, St. Croix Falls; *Leonard B. Torkelson*, Baldwin; *Elmer E. Kern*, Mukwanago; and *Dowe P. Cupery*, Markesan.

Dr. Stebbins Elected Honorary Member

Dr. George G. Stebbins, Madison, recently was elected to honorary membership on the Community Welfare Council's Committee on the Aging, it was announced by *Dr. Frederick W. Blancke*.

Dr. Strebe Guest Speaker

Dr. K. L. Strebe, Oconto Falls, recently was the guest speaker before the Woman's Hospital Auxiliary meeting. His topic was "Where the Community Stands" as far as a 'new hospital' is concerned.

Dr. Manz Featured in PR/DR

Dr. Walton R. Manz, Eau Claire, recently was featured in the AMA's publication, PR DOCTOR. Doctor Manz was noted for his outstanding dedicated service to his 10 year presidency of the Eau Claire Board of Education. A new elementary school was named after him and at the same time an oil portrait, in recognition of his foresightedness in purchasing land for proposed school sites long before land costs were prohibitive and school facilities became overcrowded, was unveiled. Doctor Manz is chief-of-staff and of surgery at Sacred Heart Hospital and on the staffs of three others in Eau Claire, Chippewa Falls, and Neillsville. He is a past president of the Eau Claire–Dunn–Pepin County Medical Society, a past president of the Wisconsin Academy of General Practice and now chairman of its board, and chairman of the Eau Claire County advisory committee to Wisconsin Physicians Service, the Blue Shield plan of the State Medical Society. He also served the Division on School Health of the State Medical Society's Commission on State Departments.

Drs. Hughson Return from Taiwan

Drs. Donald and Frances *Hughson*, Milwaukee, recently returned from spending a month in Taiwan doing missionary work. They volunteered their services for a month at the Maryknoll mission clinic in Changhua, Taiwan. They were accompanied by *Dr. William H. Bennett*, Racine, and his wife. Mrs. Hughson is a graduate of Marquette University School of Medicine and her husband is a graduate of Yale University Medical School.

Dr. Tullett Joins Clinic

Dr. Geoffrey Tullet, Leeds, England, recently joined The Monroe Clinic as an internal medicine specialist. Two other physicians, *Drs. Thomas L. Watt* and William R. Austand, left the clinic to commence military duty.

Doctor Asplund Guest Speaker

Dr. M. W. Asplund, Bloomer, recently was the guest speaker at a Kiwanis Club meeting. He spoke on the recent heart transplant operations.

Doctor Steffen Guest Speaker

Dr. Elizabeth A. Steffen, Racine, recently was the guest speaker before a meeting of St. Luke's Hospital Auxiliary. Doctor Steffen recently spent nine weeks aboard the floating medical center, S. S. HOPE.

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PHYSICIAN NEWS *continued*

Doctor Weiland Featured in Newspaper

Dr. H. P. Weiland, Verona, recently was featured in the VERONA PRESS for forming the first organized basketball team in the Verona area. Doctor Weiland and wife, Calla, who moved to Verona in 1921, realized there was little activity for the younger boys and immediately set forth and started a basketball team. After basketball, it was a swimming pool and ice skating rink, and on Friday night when the basketball games are played, their efforts are a tribute to the earlier leadership of Doctor Weiland.

Dr. Glenn Smiley Instructs Boy Scouts

Boy Scouts in the Delavan area were given instruction in life-saving techniques by *Dr. Glenn Smiley* at a meeting February 5. During the practice session, in which Doctor Smiley used a special mannequin, the Scouts were shown the correct methods of applying external cardiac heart massage, mouth-to-mouth resuscitation, and mouth-to-nose resuscitation. In addition to the demonstration, Doctor Smiley stressed the importance of knowing the right time and how to use the three techniques.

Dr. Hirschboeck Talks in La Crosse

Dr. John S. Hirschboeck, coordinator of the Wisconsin Regional Medical Program and 1968 campaign chairman of the Wisconsin Heart Association, addressed members of the La Crosse Kiwanis Club in late January.

Doctor Hirschboeck noted that today's medical research isn't aimed at "making man immortal" but at making the normal life span as healthy and enjoyable as possible. Heart transplants, he warned, can't be thought of as a general answer to heart disease. A complete artificial heart may be the ultimate solution but is some years away, he noted. More patients will be helped with heart valve repair or replacement, or surgical replacement of arteries to the heart muscle, he said.

Doctor Hirschboeck's appearance was the first in a series of talks in La Crosse in support of the heart fund campaign.

Dr. Hildebrand Named to Sears Foundation

Announcement was made in February of the election of *Dr. William B. Hildebrand* of Menasha to the Board of Directors of The Sears–Roebuck Foundation. The Sears–Roebuck Foundation is a non-profit corporation organized and endowed by Sears, Roebuck and Co. to carry on charitable, scientific and educational activities. It currently supports more than 1,000 programs throughout the nation in the fields of education, youth activities, community improvement, and community medical assistance. Several communities in Wisconsin have benefited from the Foundation's support.

Doctor Hildebrand, administrative director of Riverside Clinic, Menasha, has served as a con-

sultant on medical programs of the Foundation, and is a former chairman of the Foundation's advisory board on medical programs.

Among other national associations, Doctor Hildebrand is a member of the Joint Commission on Accreditation of Hospitals and the American Medical Association's ad-hoc committee on hospital accreditation. He also is a past president of the State Medical Society of Wisconsin.

Physicians Named to AMA Committees

Eight Wisconsin physicians have been named to various committees of the American Medical Association, according to recent announcement by Dr. Wesley W. Hall, chairman of the AMA's Board of Trustees.

Dr. John O. Simenstad, Osceola, has been appointed a member of the Committee on Medicine and Religion. This Committee, composed of both physicians and clergymen, works to create the proper climate for communication between the physician and the clergyman that will lead to the most effective care and treatment of the patient in whom both are interested. To achieve this purpose, the Committee, working through physicians at the local level, establishes contacts with the clergy and directs studies in areas where there is continuing correlation involving medicine and religion.

Dr. Francis M. Forster, Madison, has been reappointed a member of the Committee on Rehabilitation. The Committee, currently composed of six members, is concerned with the coordination of information to physicians on various aspects of rehabilitation.

Dr. Oscar A. Sander, Milwaukee, has been reappointed chairman of the Subcommittee on Hematopoietic and Lymphatic Systems of the AMA's Committee on Rating of Mental and Physical Impairment. *Drs. Armand J. Quick* and *Anthony V. Pisciotta*, Milwaukee, have been reappointed members of the same Subcommittee. The AMA Committee on Rating of Mental and Physical Impairment is developing a series of practical guides to assist physicians in evaluating permanent impairment. Each guide is prepared by a group of specialists concerned with the area of the body being considered.

Dr. Ewald Pawsat, Fond du Lac, has been reappointed a member of the Council on Voluntary Health Agencies. The AMA Council maintains liaison between the AMA and national voluntary health agencies, taking an active interest in national studies and programs in this area. It offers services to these agencies on matters concerned with medical care, medical research, health education, and medical profession relationships and, in turn, provides physicians and medical societies with information concerning these agencies.

Dr. Allan J. Ryan, Madison, has been appointed chairman of the Committee on Exercise and Physical Fitness and *Dr. James C. H. Russell*, Fort Atkinson, has been reappointed a member.

The AMA Committee makes recommendations on AMA activities relating to physical fitness, the relationship of exercise to health, and AMA physical fitness activities with respect to those of other private and public agencies interested in fitness.

The Committee has published a number of pamphlets and brochures designed to help improve the health and fitness of the American people.

Periodically the Committee sponsors a meeting of representatives of national agencies interested in fitness with the objective of improving communication and coordination in this important area.

Marquette Dermatologist Grant Recipient

Dr. David W. Kersting, professor and chairman, Department of Dermatology, Marquette School of Medicine, Milwaukee, recently received a $5,000 grant from The Dermatology Foundation for the improvement of dermatology teaching and patient care. The Foundation, which is just completing its second year of operation, is a national, privately financed organization with some 1,200 members.

Anesthesiology Exhibit

A new exhibit honoring the late Elmer Isaac McKesson, one of anesthesiology's most distinguished pioneers, has been installed at the Wood Library–Museum, which adjoins American Society of Anesthesiologists Headquarters in Park Ridge, Ill.

The memorial tribute to the late Doctor McKesson (1881–1935) highlights his many contributions in scientific administration of gaseous anesthetics, classification of anesthetic risks, and charting of circulatory and respiratory parameters during surgery. In a lifetime devoted to progress in anesthesia technique and research, Doctor McKesson contributed many valuable articles to international literature. Copies of his published works occupy a prominent place in the museum's archives.

One of his most important inventions was a gas machine with intermittent flow, which he invented in 1910. This is included in the exhibit along with one of his early NARGRAPH monitoring machines. This made it possible to record the percentage of oxygen administered during anesthesia, respiration, volume of re-breathing, systolic and diastolic blood pressure, and the pressure with which gases were administered.

The McKesson exhibit is the newest in the museum, which includes a number of other noteworthy displays pertaining to the art and science of anesthesia. With each new acquisition, the museum's preeminence increases as the major repository of examples of the specialty's development.

The library is gradually acquiring one of the finest collections in the world of writings on anesthesia. This includes many rare volumes, scientific papers and illustrative materials.

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardi arrhythmias have occurred in hyp thyroid patients and in patients re ceiving thyroid medication when Tofrānil was added to the regime Imipramine may block the pharm cologic activity of guanethidine a other related adrenergic neuron-blocking agents.
The drug is not recommended at present time in patients under 12 of age.
Adverse Reactions: Dryness of th mouth, tachycardia, constipation, turbances of accommodation, sw ing, dizziness, weight gain, urinar frequency or retention, nausea an vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors rare cases of falling in elderly patients, confusional states (with su symptoms as hallucinations and d orientation), activation of psycho schizophrenics and agitation (inc

COUNTY SOCIETIES

BROWN

Dr. Martin A. Adson was guest speaker at the January 11 meeting of the Brown County Medical Society. He discussed several radiological diagnostic procedures and their application to abdominal surgery. Presiding at the business meeting, which preceded the scientific program, was the new president, *Dr. Leonard Miller.*

CHIPPEWA

Dr. E. F. Hill of Eau Claire spoke on "Menopause: Sense or Nonsense" at the February 6 meeting of the Chippewa County Medical Society.

DANE

A joint meeting of the Dane County Medical Society and the Dane County Pharmaceutical Society was held February 13 in Madison. The program included a panel discussion on "Narcotics, Telephone Prescribing, and Laws Relating to Drug Dispensing."

DOUGLAS COUNTY MEETING — *Dr. Oscar A. Farias*, left, president of the Douglas County Medical Society, introduced the speaker, *Dr. Fred J. Hofmeister*, center, at the February meeting. *Dr. Robert Mataczynski*, right, president-elect for 1969, also welcomed the speaker. (Photo courtesy THE EVENING TELEGRAM, Superior)

DOUGLAS

Members of the Douglas County Medical Society met February 7 in Superior and heard *Dr. Frederick J. Hofmeister* of Milwaukee discuss "The Complete Office Gynecological Examination." Doctor Hofmeister is associate clinical professor of medicine at Marquette School of Medicine, president-elect of the Central Association of Obstetricians and Gynecologists, district chairman and vice-president of the American College of Obstetricians and Gynecologists, and chairman of the Department of Obstetrics and Gynecology, Lutheran Hospital, Milwaukee. *Dr. Oscar A. Farias*, society president, presided at the meeting and introduced the speaker.

KENOSHA

"Renal Transplants" was the subject of Dr. Clarence B. Hewitt's talk before 63 members of the Kenosha County Medical Society February 1 in Kenosha. Doctor Hewitt is from the Cleveland Clinic.

RICHLAND

Dr. Gordon Davenport, Jr. of Madison was guest speaker at the January 4 meeting of the Richland County Medical Society in Richland Center. Doctor Davenport, who specializes in plastic surgery, discussed "Facial Injuries."

At the February 1 meeting, also in Richland Center, the members heard *Dr. Robert O. Johnson* talk on "Current Clinical Research in Cancer." He is an associate professor of surgery at the University of Wisconsin Medical Center.

WALWORTH

The January 18 meeting of the Walworth County Medical Society was held at Lake Geneva. *Dr. Muhammed Rafiullah*, a neurosurgeon in Racine, discussed "Stroke." At the business session discussion centered around a proposed multi-county special meeting for June.

WAUKESHA

"Plastic Surgery" was the topic given by Dr. Paul Natvig of Milwaukee at the February 7 meeting of the Waukesha County Medical Society. Fifty-three members and their wives attended the dinner meeting at the Tumblebrook Country Club. While the physicians listened to Doctor Natvig, the auxiliary heard a landscape architect explain "Landscaping the Home Grounds."

Doctor Natvig, a plastic surgeon in Milwaukee, has both DDS and MD degrees and is co-author of a textbook on facial fractures, published in 1963.

WINNEBAGO

Dr. L. D. Graber of Oshkosh was the guest speaker at the Jan. 4 meeting of the Winnebago County Medical Society. His topic was "Tours of Medical Centers of the British Isles."

Officers installed at this meeting were *Dr. Eugene N. Wright* of Oshkosh, president; *Dr. Donald J. Ryan* of Neenah, vice-president; and *Dr. George W. Arndt, Sr.* of Neenah, secretary–treasurer.

Physicians whose names appear in italics are members of the State Medical Society.

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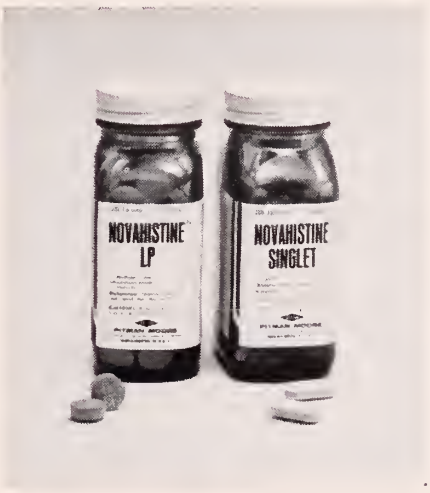

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SPECIALTY SOCIETIES

Wisconsin Dermatological Society

Dr. James W. Bringe, Sheboygan, president of the Wisconsin Dermatological Society, presided at the February 3 meeting of the group in Milwaukee at Milwaukee Children's Hospital. Guests of the state's dermatologists were members of the Chicago Dermatological Society and the Great Lakes Naval Station.

Subject of the meeting was the presentation of 25 patients with diagnostic and therapeutic problems for discussion.

Arrangements were also made by Doctor Bringe with Dr. Arthur C. Curtis of Ann Arbor, Mich., and Dr. Derek J. Cripps of Madison to be special lecturers at the State Medical Society's Annual Meeting in May in Milwaukee. The two physicians will focus their discussions on the collagen diseases of the skin. Current interest and research in this group of diseases of the connective tissues centers in photosensitivity and auto-immunity which Doctor Bringe noted should be of interest to many. Complete details of the dermatology portion of the SMS Annual Meeting appear elsewhere in this issue.

Milwaukee Academy of Medicine

The Arthur W. Rogers Memorial Lecture was presented by Dr. Loyal Davis to members of the Milwaukee Academy of Medicine meeting February 20 at the University Club of Milwaukee. Doctor Davis is professor of neurosurgery at Northwestern University Medical School.

Wisconsin Society of Pathologists

The mid-year (Spring) meeting of the Wisconsin Society of Pathologists will be held June 7–9 at Eagle Waters Resort, Eagle River.

The scientific program will be held on Saturday, June 8. There will be a morning presentation of scientific papers by members and residents. An afternoon seminar on Pitfalls in Dermatopathologic Diagnosis will be moderated by Dr. Arthur C. Allen, Jewish Hospital, Brooklyn, N.Y. The day will conclude with a meeting of the Board of Directors, followed by dinner.

The Fall meeting of the Society will be held November 16 at Marquette School of Medicine, Milwaukee.

At last Fall's annual meeting, the following officers were elected: president, *Dr. Joseph L. Teresi*, Brookfield; vice-president, *Dr. William G. Richards*, Beaver Dam; secretary and councilor to ASCP, *Dr. David J. La Fond*, Elm Grove; treasurer, *Dr. Chesley P. Erwin*, Elm Grove; delegate to SMS, *Dr. Robert Scheidt*, Milwaukee; alternate delegate to SMS, *Dr. Lars Kleppe*, Beloit; senior assemblyman to CAP, *Dr. Norbert G. Enzer*, Milwaukee; and junior assemblymen to CAP, Doctors Richards and *Dr. David J. Carlson*, Milwaukee.

Physicians whose names appear in italics are members of the State Medical Society.

KILLED MEASLES VACCINE SHOULD NO LONGER BE USED

The American Academy of Pediatrics recently recommended that inactivated (killed) measles vaccine no longer be used, and that live, attenuated measles vaccine be given as soon as possible to children who may have received only the killed type of vaccine. In a statement appearing in the Academy's November 15 *Newsletter*, the AAP Committee on Control of Infectious Diseases also suggests that parents be cautioned about possible local and systemic reactions which may occur when children who have received the killed vaccine are later exposed to measles.

The statement also points out that some children who have received the live, attenuated form of vaccine following inoculation with the killed type, have experienced heat, tenderness, swelling of the lymph nodes, and malaise. A third recommendation calls for children who have underlying illness, or who receive forms of therapy which may render inadvisable the use of live vaccines, to be given immune globulin (human) "for protection or exposure to measles."

The Academy statement emphasizes that the magnitude and incidence of these reactions must still be determined. But in one town, 11 of 66 children developed abnormal illness when exposed to natural measles "4 years after administration of inactivated vaccine." In another area, 9 of 31 children had local reactions when given live vaccine "one year after a course of inactivated antigen."

"Reactions of this sort have not been observed with live, attenuated virus vaccine or natural measles unless prior sensitization had been induced by the inactivated vaccine," the statement concludes. Although the development of these reactions has not been fully clarified, "their severity and frequency, and the likelihood that less overt, unrecognized forms may occur, justify a reconsideration of the use of this vaccine at this time."

Gundersen Medical Foundation Meeting

A grant of $50,000 was given to the Adolf Gundersen Medical Foundation at its 24th annual meeting February 14 in La Crosse. *Dr. Alf H. Gundersen*, vice-president of the Foundation and the donor, made the contribution to aid newly developing local heart research programs. The fund has been placed in a separate account to be known as the "cardiac research fund." The cardiac research is to be carried out as a joint project of the Gundersen Clinic and La Crosse Lutheran Hospital where personnel for a few years have been performing open heart surgery. Dr. Alf Gundersen and two of his brothers, *Dr. Gunnar Gundersen* of La Crosse and *Dr. Sigurd Gundersen* of West Salem, in 1944 set up the Foundation and named it for their father, Dr. Adolf Gundersen, who founded the Gundersen Clinic. The Foundation is dedicated primarily to medical education and research.

Featured speaker at the meeting was Dr. Austin E. Smith, president and chairman of the board of Parke, Davis & Co. of Detroit, Mich. Doctor Smith noted that "everyone is in the act" on governmental levels in shaping medical, hospital, and drug care for individuals today. The main target, he said, is the consumer, or voter.

Doctor Smith talked on "The Growth of Consumerism" and based much of his talk on the seven years he spent in Washington, D.C. as an executive for the drug industry. Noting that he became disillusioned after the years in Washington, Doctor Smith said there was a time when just a few professional persons were involved in patient care. The government today "is the most vocal."

The 55-year-old physician and pediatrician frankly told the audience of 75 persons that a great deal of private research by foundations—similar to the Gundersen foundation—may well "dry up" under present trends. He said the fee and profit system, "dirty words" to some persons, needs to be explained chiefly to the young.

First Multiple Sclerosis Clinic

The first multiple sclerosis clinic in the East-Central Wisconsin area was held at St. Vincent Hospital, Green Bay, February 26–27. The clinic was a coordinated effort of the Green Bay medical community and the University of Wisconsin, and was approved by the Brown County Medical Society. Patients were seen in the clinic only on referral from the personal physicians who will be kept informed of evaluations and recommended therapy programs.

This clinic is the first in a program of regular clinics to be offered in Green Bay every two months in the future. Last year the University Neurological Clinic started accepting referred sclerosis patients for one day of consultations and tests, with the hope of expanding the clinics to regional locations.

Neurosurgical Conferences Planned

Formation of a series of neurosurgical conferences to be held the second Tuesday of each month, beginning at 4:30 p.m., was announced by the Adolf Gundersen Medical Foundation of La Crosse in mid-February. The conferences, which started Tuesday, February 13, in the conference room of the Lutheran Hospital in La Crosse, will be concerned with basic neurological problems. Epilepsy was the topic of the first session.

All La Crosse area physicians, nurses, medical students, and technicians may attend. Persons wishing to participate may contact Dr. C. Norman Shealy, Department of Neurosurgery, Gundersen Clinic, La Crosse.

Wisconsin State Medical Assistants Society

A record registration of 271 members and guests of the Wisconsin State Medical Assistants Society met February 3 in Milwaukee at the Holiday Inn Central for their ninth annual educational symposium.

A panel discussion on medical emergencies was presented by Drs. Nicholas Domiano, Hales Corners; *Donald J. Chrzan*, Milwaukee; and *Thomas H. Kawalski*, Milwaukee.

Speakers also included Mrs. B. A. Biggs, R.N., supervisor of Central Services for Milwaukee County Hospital; Mrs. Robert Lane, R.R.L., former instructor in the medical secretary course at Milwaukee Institute of Technology; and Joseph M. Staudacher, professor of speech at Marquette University, Milwaukee.

The thirteenth annual meeting of the Society will be held June 7–9 in Milwaukee.

Dodge County Medical Assistants

The Dodge County Medical Assistants Society met February 6 and were guests of the Clinical Pathology Laboratory, Beaver Dam. *Dr. Paul R. Glunz*, Beaver Dam, a member of the consultant physicians in Pathology, transmitted variant aspects of the clinical pathologist's work via descriptive colored slides and conversed on the concreteness of his work in medical care.

President Mrs. Verlyn Straseski conducted the business meeting. State president, Miss Donna Schultz, and *Dr. Harold J. Kief* of Fond du Lac, president of the State Medical Society of Wisconsin, opened the program. Topics presented by authoritative persons were: "Where Is That Record?," "How You File Does Make a Difference," "Do I Sound Like That?," "The Experts Answer—What Is An Emergency?," and "Work Smarter and Not Harder."

Physicians whose names appear in italics are members of the State Medical Society.

Waukesha County Medical Assistants

The Waukesha County Medical Assistants Society met January 17 at the Waukesha County Technical Institute in Waukesha to hear *Dr. Wayne Konetzki*, a Waukesha internist, speak on the Digestive System.

The Society's educational programs are patterned after the AAMA Certification Exam outline as part of a continuing educational program eventually leading to certification.

International Society of Medical Directors

Dr. Bertram B. Moss, author of "Caring for the Aged," was elected president of the International Society of Medical Directors of Chronic Disease Facilities at the first annual meeting of the Society held in Houston, Tex., Nov. 30, 1967. Other officers elected at the meeting are: Dr. Thomas C. Kalkhof, president-elect; Dr. Raymond T. Benack, vice-president; and Dr. Vincent C. Sarley, secretary-treasurer.

The next meeting of the Society will be held immediately following the American Medical Association Clinical Conferences on Thursday, December 5, at the Americana Hotel in Florida.

Inquiries regarding the Society and its activities should be directed to: Patricia Morgan Dorr, Executive Director, Suite 1003, 360 North Michigan Ave., Chicago, Ill. 60611; tel. 346–7133.

Hospitals Announce Cooperative Project

The University of Wisconsin Hospitals, Madison, and the Sauk Prairie Memorial Hospital, Prairie du Sac, in February jointly announced the beginning of a cooperative project which will extend the University Hospitals' resources to the Sauk Prairie hospital.

U.S. Olympic Speed Skaters Trained and Studied in Milwaukee

Medical research had a background role in the Winter Olympics which were held in February at Grenoble, France. Most members of the United States speed skating team were participants this past year and a half in studies carried out by the Marquette School of Medicine and the University of Wisconsin at Milwaukee. The results may influence future training methods.

United States speed skaters do well in short distance events which depend more upon skill than endurance. In long distance events, the Scandanavians and the Russians usually surpass us. The answer obviously lies in the intensity of training, but medically speaking, why is this so?

The Milwaukee studies were begun in response to such a question from a 1964 member of the U. S. Olympic skating team, Barbara Lockart of West Allis, Wis. She wanted to know if medical tests might predetermine a skater's performance. She knew that skill was not measurable, but observed that equally skilled skaters do not perform at the same level of endurance.

Dr. Lyle H. Hamilton, associate professor of Physiology at Marquette, and Dr. Michael G. Maksud, associate professor of physical education and director of the exercise physiology laboratory at UWM and also a Marquette research appointee, first took her question to the laboratory and then to the county's only artificial Olympic-sized skating rink located in Milwaukee. Most of the U. S. Olympic contenders have trained here.

In the laboratory, the skaters were tested on a treadmill where the effects of various workloads on the heart and lungs were recorded. During training sessions at the rink, the skaters donned a welder's helmet equipped with a breath collecting bag. Their heart rates were telemetered to recording equipment located nearby.

The researchers find that the only lung function differences between skaters and known measurements for normal healthy adults appear to be the skaters increased ability to empty their lungs of air. They believe that this is due in part to better chest and abdominal muscle development.

What sets the limit on athletic performance is the cardiovascular system. The Marquette–University of Wisconsin–Milwaukee studies support other findings which show that the energy demands of hard working muscles are met by a gradual build up of the heart and blood vessel network which carries greater supplies of blood with oxygen and nutrients for refueling. It is a case of supply and demand.

It is also a case of mobilization. The trained skater is able to mobilize his cardiovascular system quickly and reach an early and high point of maximum oxygen uptake. Oxygen uptake is considered the single best test for measuring endurance. Oxygen's role is critical because it is necessary for the breakdown of foods into energy. Normally, the stored nutrients in the body are sufficient to sustain vigorous activity for long periods of time provided there is no deficiency of oxygen. The superior cardiovascular system of the athlete assures high levels of oxygen.

Doctors Maksud and Hamilton's tests showed an average maximal oxygen uptake for men skaters of 4.14 and for women 2.78 liters per minute. The highest uptake ever recorded was over five and one-half liters for a Swedish cross-country skier. Cross-country skiing develops a high capacity for oxygen utilization with skating, running, and swimming close runners-up. The common factor in all of these sports is prolonged activity rather than sudden bursts of energy.

Since adequacy of training for endurance to compete successfully is reflected in oxygen uptake, the Marquette–University of Wisconsin–Milwaukee studies may serve as an index for measuring a skater's need for more vigorous training, depending upon the event in which he plans to compete.

The research is being supported by the Wisconsin Heart Association.

Under the arrangement, experienced staff members at University Hospitals will be available on a continuing basis to help the community hospital solve problems and develop new programs, according to Edward J. Connors, superintendent of University Hospitals. Mr. Connors and Wilbur C. Beach, administrator of the Sauk Prairie Hospital, expect the project to give both hospitals a better understanding of such problems as the rising costs of health care and the chronic shortage of skilled paramedical personnel.

According to Webster Sprecher, president of the Sauk Prairie Memorial Hospital Board of Directors, it is hoped that this project will eventually provide additional services and resources which will help Sauk Prairie hospital improve existing programs and develop new ones.

The project will also enable the University Hospitals to achieve increased understanding of community hospital operations and a better appreciation for the health problems of Wisconsin communities.

Mr. Connors pointed out that the program essentially is an extension of the "Wisconsin Idea" within the area of health care. He said that he hopes the project will serve as a model for other cooperative efforts between the University Hospitals and community hospitals throughout the state.

Sacred Heart Rehabilitation Hospital Modernizes

A major modernization program is under way in Milwaukee at Sacred Heart Rehabilitation Hospital, a Wisconsin institution devoted exclusively to physical rehabilitation.

The first stage in the $300,000 program was completed February 3 when 25 patients were moved into a newly remodeled and refurbished second floor.

The modernization includes all five stories of the landmark hospitals south wing, which was built in 1929 and is located at 1545 South Layton Boulevard, Milwaukee. The classical front section, with its familiar bell tower, was constructed in 1893.

With completion scheduled for about May 1, the work is being done in stages so that regular patient care and treatment will not be disrupted, according to Sister Frances Ackeret, hospital administrator.

Until two years ago Sacred Heart specialized in the treatment of chronic illnesses, arthritis, and emotional and medical disorders. The hospital now specializes in rehabilitating victims of strokes, fractures, spinal injuries, amputations, chronic neurological defects, arthritis, and cardiac-pulmonary conditions.

The hospital, operated by the School Sisters of St. Francis, serves patients from throughout the Wisconsin area, many of whom are referred by doctors from other hospitals.

"Sacred Heart is being developed according to guidelines of the Regional Medical Program, which is designed to avoid duplication of facilities and services while providing optimum patient care at lowest possible cost," said Sister Frances.

The hospital has a staff of about 220 persons, and a medical staff of about 75 doctors representing all medical specialties.

Waukesha Memorial Hospital Workshop

Waukesha Memorial Hospital was host to more than 100 Wisconsin physicians and nurses at an all-day workshop January 24 on care of the premature infant. The program was sponsored by the Section of Maternal and Child Health of the Bureau of Community Health Services of the Division of Health of the State Department of Health and Social Services, in cooperation with the University of Wisconsin Medical Center and the State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments.

The three featured speakers were: *Dr. Stanley Graven*, assistant professor of pediatrics, University of Wisconsin Medical Center, and director of the Hartford Neonatal Laboratory, St. Mary's Hospital, Madison; *Dr. Gertrude Howe*, director of the Bureau of Community Health Services; and Dr. John Grausz, director of newborn nurseries, Milwaukee County Hospitals.

Cudahy Hospital Medical Staff Meets

Milwaukee county executive, John Doyne, was the main speaker at the annual meeting of the Trinity Memorial Hospital in Cudahy January 23. His re-

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marks centered around a report on the proposed medical center for the Greater Milwaukee Area.

Mr. Doyne said that the findings of the Governor's Task Force on Medical Education indicated that the location of the Marquette medical school and the proposed University of Wisconsin–Milwaukee medical school, both situated in Milwaukee, and the University of Wisconsin–Madison medical school make these the logical centers for the development of a comprehensive medical center.

He further said that he felt Milwaukee was indeed fortunate in the caliber of physicians in the county. He cited as an example the excellence of Trinity's staff the fact that *Dr. Joseph Mueller*, Milwaukee County Civil Defense Training Director, in his opinion, "knows more about the relationship of the doctor and civil defense than any other doctor in the United States."

Host for the meeting was *Dr. Rocco Latorraca*, Trinity's chief of staff.

Merrill Physicians Show Mental Illness Film

Merrill physicians sponsored a film of trends in the treatment of mental illness within a comprehensive community mental health program. The film, entitled "The Bold New Approach," was shown in the Merrill Senior High School February 18 to the general public. It is highly recommended as an educational tool to increase public understanding of the new concepts in mental health. A resource person associated with the Marathon County Mental Health Center was present to answer questions.

Winnebago Alcoholism Committee Formed

Representatives from health and social services agencies on February 9 formally organized a committee to investigate the extent of alcoholism in Winnebago County and to determine the need of services to aid this problem. The committee voted to call itself the Winnebago County Alcoholism Committee. Staff members of the Winnebago State Hospital assisted in the organization.

Hospital Course in Human Relations

John C. Kadon, public relations counsel, has begun a series of classes in Internal Human Relations for supervisory personnel at St. Francis Hospital, Milwaukee.

Aiding him in setting up the three programs, which will include lectures, films, and reference booklets, are Mrs. Rose Reitz, Continuing Education Director of the hospital, Richard Fronsoe, Personnel Director and Sister M. Teresilda, Director of Nursing Services.

NEW IMMUNIZATION GUIDE FOR ADULTS

Publication of a new working manual for doctors and other health personnel on the subject of immunizations for adults has been announced by the American College Health Association (ACHA).

The 55-page, spiral-bound booklet entitled *Adult Immunization Guide* describes immunization procedures for some 19 infectious diseases. It was prepared by the ACHA's Committee on Immunizations and printed under a grant from Lederle Laboratories Division of American Cyanamid Company.

Commenting on the new publication, ACHA President Dr. Donald L. Cooper said: "While good references are available for immunization of infants and children, this new booklet provides the medical profession with clear and concise guidelines for immunization of adults against infectious diseases. It is an attempt to give practical and workable explanations regarding many unsettled aspects of immunizations." Doctor Cooper is director of health services at the Oklahoma State University in Stillwater.

Immunization procedures for each of the 19 diseases are considered in terms of 1) indications, 2) immunizing agent, 3) contraindications, 4) primary immunizations (basic series), 5) reimmunization (booster), 6) untoward effects, and 7) comments. All dosages noted are for adults (persons over 12 years of age).

Included with each copy of the Guide is a composite immunization table measuring 11 by 17 inches which may be removed from the booklet and posted on a bulletin board in the doctor's office or clinic. Purpose of the table is to serve as a quick visual reference for various immunizations showing such factors as contraindications, simulatneous immunizations to be avoided, primary and booster doses and schedules, maximum interval for effective booster recall, and international travel status.

In addition to basic information about each immunization, the booklet also contains guidelines on records and identification, international travel, immunizing schedules, equipment, injection techniques and sites, untoward effects, and motivation and education. At the conclusion of the Guide there is a bibliography of references for each immunization listed as well as for the general subject of immunization.

Information on how to secure copies may be obtained by writing the American College Health Association, Box 9117, University of Miami Branch, Coral Gables, Fla. 33124.

The first class, held at the hospital Wednesday, February 14, included a lecture by Mr. Kadon on "Introduction to Human Relationships" and "Handling People."

On Wednesday, February 28, the guest speaker for the class was Pat Barnes, WISN-TV Public Service Director, who discussed "The Power of Enthusiasm."

On Wednesday, March 13, *Dr. Roman E. Galasinski*, State Medical Society Delegate to the American Medical Association, spoke on the history and development of St. Francis Hospital. Mr. Kadon discussed "Communicating."

Printed reference material used as background for the course and presented to class members for further study included booklets on "Everyday Human Relations," "Wonderful Power of Enthusiasm," and "Principles of Face-to-Face Communication."

Wisconsin Anti-Tuberculosis Association

"There's a pill to prevent TB" will be the theme of the WATA's 60th anniversary conference on TB, April 4 and 5 at the Pfister Hotel in Milwaukee. Speakers include Dr. Francis J. Curry, assistant director of public health for the San Francisco department of public health; *Dr. Donald M. Rowe*, medical director of the Kohler company, Kohler; and *Dr. Frank C. Stiles*, Monroe, chairman of the Wisconsin chapter of the American Academy of Pediatrics.

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Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

BOOKS RECEIVED

CLAUDE BERNARD AND EXPERIMENTAL MEDICINE
Edited by Maurice B. Visscher and Francisco Grande. Published by Schenkman Publishing Company, Inc., Cambridge, Mass. 1967. 120 pages. Price $8.95.

THE HEALTH CONSEQUENCES OF SMOKING
A Public Health Service Review: 1967, U.S. Department of Health, Education, and Welfare. 199 pages. Price 60¢.

FERTILITY AND EDUCATIONAL ATTAINMENT, Puerto Rico—1962
By U.S. Department of Health, Education, and Welfare, Public Health Service, Vital and Health Statistics, data from the National Vital Statistics System. Series 21, No. 12. September 1967. 20 pages.

SUICIDE IN THE UNITED STATES, 1950–1964
Vital and Health Statistics, data from the National Vital Statistics System. National Center for Health Statistics—Series 20, No. 5. U.S. Department of Health, Education, and Welfare, Public Health Service, Washington, D.C., August 1967. 34 pages. Price: 30¢.

UTILIZATION OF SHORT-STAY HOSPITALS, Summary of Nonmedical Statistics United States—1965
Vital and Health Statistics, data from the National Statistics—Series 13, No. 2. U.S. Department of Health, Education, and Welfare, Public Health Service, Washington, D.C., August 1967. 21 pages. Price: 25¢.

ESSENTIALS OF ROENTGEN DIAGNOSIS OF THE SKELETAL SYSTEM
Lester W. Paul, MD and John H. Juhl, MD, professors of Radiology, University of Wisconsin Medical School. Published by Hoeber Medical Division, Harper & Row, 49 East 33rd St., New York, N.Y. 10016. 1967. 280 pages. Price: $12.50.

DIABETES MELLITUS: Diagnosis and Treatment
Volume II. Editors, George J. Hamwi, MD and T. S. Danowski, MD. Published by American Diabetes Association, Inc., 18 East 48th St., New York, N.Y. 10017. 1967. 250 pages. Price: $2.50.

MILD MENTAL RETARDATION: A GROWING CHALLENGE TO THE PHYSICIAN
Formulated by the Committee on Mental Retardation. Vol. VI, Report No. 66, September, 1967. Published by Group for the Advancement of Psychiatry, 104 East 25th St., New York, New York 10010. 64 pages. Price: $1.00.

USES OF WINE IN MEDICAL PRACTICE
Published by the Wine Advisory Board, San Francisco, California 94103. Fifth Edition. August 1967. 64 pages.

THE HUMAN ADRENAL CORTEX: ITS FUNCTION THROUGHOUT LIFE
Ciba Foundation Study Group No. 27, Little, Brown and Company, Boston, 1967. 146 pages.

CHARGES FOR CARE IN INSTITUTIONS FOR THE AGED AND CHRONICALLY ILL. United States—May-June 1964
U.S. Department of Health, Education, and Welfare, Vital and Health Statistics. Series 12, No. 9. Public Health Service, Washington, D.C., Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 51 pages. Price: 35¢.

RELIEF WITHOUT DRUGS
The self-management of tension, anxiety and pain, by Ainslie Meares, MD, Doubleday & Company, Inc., 277 Park Avenue New York, N.Y. 10017. 1967. 188 pages. Price: $4.95.

DIAGNOSTIC PROCEDURES IN GASTROENTEROLOGY
Edited by Charles H. Brown, MD, Head, Dept. of Gastroenterology, Cleveland Clinic Foundation, Cleveland, Ohio. C. V. Mosby Company, 3207 Washington Blvd., St. Louis, Missouri 63103. 1967. 438 pages. Price: $19.75.

1966 FINAL REPORTS, State Mental Health Planning
National Clearinghouse for Mental Health information. U.S. Department of Health, Education, and Welfare. Public Health Service, National Institute of Mental Health, Chevy Chase, Md., 20203. 208 pages.

MODERN TREATMENT
Volume 4, No. 5. Treatment of Meningitis, guest editor, William S. Fields, MD; and Treatment of Mental Retardation, Part II, guest editor, Charles M. Poser, MD, Hoeber Medical Division, Harper & Row, Publishers, New York. Published bimonthly. 1,500 pages annually. Subscription: $16.00 per year.

MODERN TREATMENT
Vol. 4, No. 4. Advances in the Treatment of Poisoning, guest editor, Jay M. Arena, MD; and Treatment of Mental Retardation: Part I, guest editor, Charles M. Poser, MD. Hoeber Medical Division, Harper & Row, Publishers, New York. Published bimonthly. 1,500 pages annually. Subscription: $16.00 per year.

ANTILYMPHOCYTIC SERUM
Ciba Foundation Study Group No. 29, Little, Brown and Company, Boston, 1967. 165 pages.

MYOTATIC, KINESTHETIC AND VESTIBULAR MECHANISMS
Ciba Foundation Symposium, edited by A. V. S. De Reuck and Julie Knight. Little, Brown and Company, Boston, 1967. 331 pages. Price: $13.50.

DRUG RESPONSES IN MAN
Ciba Foundation Symposium, edited by G. E. W. Wolstenholme and Ruth Porter. Little, Brown and Co., Boston, 1967. 257 pages. Price: $13.00.

CHARACTERISTICS OF PERSONS WITH DIABETES, United States—July 1964-June 1965
Vital and Health Statistics, National Center for Health Statistics—Series 10, No. 40. U.S. Department of Health, Education, and Welfare, Public Health Service, Washington, D.C., October 1967. 44 pages. Price: 35¢.

DIVORCE STATISTICS ANALYSIS: United States—1963
Vital and Health Statistics, National Center for Health Statistics—Series 21, No. 13. U.S. Department of Health, Education, and Welfare, Public Health Service, Washington, D.C., October 1967. 57 pages.

BABY AND CHILD CARE
Benjamin Spock, MD, published by the Benjamin Company, Inc., 485 Madison Ave., New York, N.Y. 10022. Revised edition. 626 pages. Price: 50¢.

NEUROPSYCHIATRY IN WORLD WAR II, VOLUME I, ZONE OF INTERIOR
Medical Department United States Army, Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. 826 pages. Price: $7.50.

OBITUARIES

Dr. D. F. Hudek, 75, Bloomer, died Jan. 1, 1968, in Bloomer.

Doctor Hudek graduated from the Marquette School of Medicine in 1915 and interned at Milwaukee County General Hospital. He was commissioned a captain in World War I and served overseas. After service, Doctor Hudek practiced medicine in Princeton and then moved to Bloomer in 1927 where he practiced until his retirement in 1966. In 1965, he was honored by the Marquette University for having given 50 years to the medical profession.

He was a member of the Chippewa County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Floye; a daughter, Mrs. James Dahl, New Auburn; and a son, Dallas, Minneapolis.

Dr. Albert H. Lahmann, 65, Milwaukee, died Jan. 5, 1968, in Milwaukee.

Doctor Lahmann graduated from the University of Wisconsin and the Johns Hopkins Medical School, Baltimore. He practiced in Milwaukee until 1947 when he became chief-of-staff at Coronado Hospital, Coronado, Calif. In 1960 he retired and returned to Milwaukee.

He was a fellow of the American College of Surgeons and a member of the Central Association of Obstetricians and Gynecologists and the Milwaukee Academy of Medicine.

Surviving are his widow, Florence; four daughters, Mrs. Theodore Mortonson, Whitefish Bay; Mrs. W. LaMar Eisenman, Riverside, Calif.; Mrs. Roger Faubel, La Mesa, Calif.; and Mrs. Aubrey W. Carson, Coronado, Calif.; and a son, A. Frederick, Potomac, Md.

Dr. Frank J. Schubert, 75, Milwaukee, died Jan. 5, 1968, in Milwaukee.

Doctor Schubert graduated from the Marquette University School of Medicine in 1916 and interned at Providence Hospital, Detroit. He served as an army doctor in World War I. Doctor Schubert was also on the staff of St. Luke's and St. Francis hospitals in Milwaukee.

Doctor Schubert was a member of The Medical Society of Milwaukee County, American Medical Association, and was inducted into the "50 year" club of the State Medical Society of Wisconsin in 1966.

Surviving are his widow, Isabel; and two sons, Dr. Thomas, Bremerton, Wash.; and James, East Troy.

THE PHYSICIAN'S CAREER: A NEW AMA PUBLICATION FOR PHYSICIANS

Despite the remarkable changes which have occurred in patterns of medical practice, the enormous expansion of professional and occupational resources on the allied health team and the explosive growth of community health services involved in total health care within the past generation, few changes have been made in the medical school curriculum to help prepare the new physician to grasp, appreciate and meet these accelerating socio–economic challenges once he enters practice.

As a step toward surmounting this educational void, the American Medical Association has developed a new publication, *The Physician's Career*, a 99-page handbook intended to serve as a teaching outline on medical practice and community relations for physicians and medical students.

More than two years in the making, *The Physician's Career* was the direct result of suggestions made at recent meetings of the House of Delegates that teaching outlines of informative material on medical ethics, medical civics and socio–economic aspects of medical practice be provided to medical schools and medical societies for orienting students and recent graduates to nonscientific aspects of the physician's career.

Fifteen AMA departments and a task force of staff consultants cooperated in producing *The Physician's Career*, the most significant publication covering this broad subject since Joseph Garland, M. D., Boston, introduced *The Physician and His Practice* in 1954. Henry F. Howe, M. D., Director of the Department of Occupational Health, served as coordinating editor.

The AMA is encouraging state and county medical societies to utilize *The Physician's Career* as a springboard of ideas for orientation seminars for newly installed members. Copies are being provided free to members of this year's senior medical school classes. Review copies have been sent to all state and county medical societies and medical schools.

For others, single copies are available at 75 cents each from the AMA Order Department (90 cents to those in all countries except the U.S., its possessions, Canada and Mexico.) A reduced price of 45 cents a copy has been set for medical students, interns and residents.

* * *

In 1966 approximately 1,400 doctors getting a first license to practice medicine on their own in the United States were foreigners and/or graduates of foreign medical schools. This represents 19% or one-sixth of all newly licensed physicians in the United States in 1966.

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Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

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PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physician placement, sale of medical practice or equipment of a physician, sale or lease of medical buildings, etc. (Widows of deceased member physicians are allowed to advertise without charge.) There is no additional charge for ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

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WANTED: Young General Practitioner, Internist, Pediatrician, and EENT man, to associate with 10-man group. New clinic building on 12 acres next to 100-bed hospital located northwest Waukesha County. Salary with partnership opportunity after first year. Contact Dept. 276 in care of the Journal. 10tfn

WISCONSIN GENERAL PRACTICE: Gross $72,000. New building, equipment; lease, rent, sale; hunting, fishing, skiing, college town, 9,000; one hour from Minneapolis–St. Paul; leaving for residency. Contact Dept. 289 in care of the Journal. p3

SEVENTEEN-MAN Wisconsin group located in college community of 40,000 with excellent hospital facilities is seeking additional associates in the following areas:

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3. General Practice

For further information, please contact D. R. Griffith, M.D., Midelfart Clinic, Eau Claire, Wis. 10–3

THREE MAN GROUP in Northwest Wisconsin Resort, State Conservation, and Retirement Area need two more physicians adequately to serve their practice. Facilities offered are three-room physician suites, x-ray and lab under AMT technician, RN only nursing personnel. New accredited 32-bed hospital and 46-bed nursing home. Deer and duck hunting, fishing within five minutes of town. Internist most needed; generalists welcomed. Will meet any reasonable salary request. Partnership after one year. Box No. 369, Spooner, Wis. 8tfn

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FOR RENT: Deceased physician's office completely intact. Includes instruments, scale, examining table, waiting room furniture, green leather chairs, etc., cabinets. Located in the Wisconsin Tower Building, 606 W. Wisconsin Ave., Milwaukee. An ideal office for a young physician to get established. Rent: $75 monthly. Contact Mrs. John E. Haberland, 2386 North Terrace Ave., Milwaukee, Wis. 53211. g1tfn

BOARD ELIGIBLE or certified internist, EENT and urologist. 14-man, all-specialty, partnership group practice. Two modern community hospitals. New brick, two-story office located in growing community of 100,000. Contact Administrator, Kurten Medical Group, Racine, Wis. 414–637–4408. 1–3

WANTED: Physician to succeed retired Physician of City Health Dept., Racine, Wis. Located between Chicago and Milwaukee. Does not require M.P.H. Salary range $19,176–$20,448. Contact: Personnel Director, City Hall, Racine, Wis. 2–5

PEDIATRICIAN to join established department of pediatrics in 17-man midwestern group. Excellent opportunity in a growing dynamic clinic with early partnership. Town of 33,000 with two hospitals and excellent schools. Clinic staff enjoys regular vacations and time off for study. Contact Dept. 286 in care of the Journal. 2–4

INDUSTRIAL PHYSICIAN—Large heavy manufacturing company employing approximately 5,000. Progressive Medical Department staffed by 2 Physicians, 1 Dentist, 5 Nurses, and 6 Technicians. No private practice involvement. We're located one hour north of Milwaukee near the shore of Lake Michigan. Salary commensurate with experience. An equal opportunity employer. Write Personnel Director, Kohler Co., Kohler, Wis. p1–5

WANTED: GENERAL PRACTITIONER or General Surgeon willing to do general work as associate with 45-year-old General Practitioner in north central Wisconsin, town of 10,000. Full hospital privilege is available. Contact Dept. 231 in care of the Journal. m9tfn

WANTED: Well-trained General Practitioner or Internist to associate with physician in town of 5,000 in east central Wisconsin. Excellent clinic and hospital facilities. Attractive salary with possibility of eventual partnership. Contact Dept. 127 in care of the Journal. m4tfn

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APPLETON, WIS.: Downtown, choice professional building under construction. Occupancy May 1968. Air conditioned, adequate parking available, both private and public. Suites 600 to 1200 sq. ft. For details write P. O. Box 474, Appleton, Wis. p3–7

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CONTENTS

Vol. 67, No. 4 APRIL 1968

SCIENTIFIC ARTICLES

Considerations in the Preoperative Evaluation of the Major Organ Systems, by John T. Goswitz, M.D., Manitowoc ---------- 205

Multiple Endocrine Adenomatosis Presenting As Cushing's Syndrome and Concurrent Hyperparathyroidism with Massive Gastric Hemorrhage; case report with ACTH, parathyroid hormone, and gastrin assays, by Francis N. Lohrenz, M.D., F.A.C.P., Sanford R. Mallin, M.D., Edwin H. Ellison, M.D. and Ben R. Lawton, M.D., Marshfield ------- 209

Recurrent Hydatidiform Mole; report of a case of four recurrences and a review of the literature, by R. A. Diamond, M.D. and W. N. Spellacy, M.D., Minneapolis, Minn. ----- 216

William Osler's Education: Part I, by John H. Greist, M.D., Madison ---------- 219

Therapeutic Dilemmas: Acute Non-specific Benign Pericarditis (No. 6 of a Series), by Harry Beckman, M.D., Milwaukee ------ 223

Comments on Treatment: Ambulatory Management of Chronic Obstructive Lung Disease, by Gordon L. Snider, M.D., Milwaukee ---------- 229

SPECIAL FEATURES

New Tape Lectures ---------- 10

Electronic Medical Design: Tiny Flaws Can Kill (abstract) ---------- 208

Intramural Duodenal Hematoma in Children (abstract) ---------- 218

Prolonged Survival of Lymphocytes with Chromosomal Defects in Children Treated with 1,3-Bis (2-Chloroethyl)-1-Nitrosourea (abstract) ---------- 222

Wisconsin's Health: Measles Eradication Campaigns Help Reduce Incidence to New Low, and Hospital Discharge Survey, by E. H. Jorris, M.D., State Health Officer ------- 232

Vietnam Revisited, by Victor S. Falk, M.D., Edgerton ---------- 241

Section on Medical History ---------- 38

New Telephone Number: State Medical Society of Wisconsin and Its Divisions ---- 41

1968 Annual Meeting, State Medical Society 42

Wausau Clinic Reports Successful Transmission of X-Ray Picture Via Telephone Facilities ---------- 63

Museum of Medical Progress and Stovall Hall of Health: Opens April 15 ---------- 66

EDITORIALS

President's Page: Quo Vadis—The Professions, by Harold J. Kief, M.D., Fond du Lac 233

In Memoriam: John H. Houghton, M.D. ---- 235

Familial Disease, Rapport, and Consent, by Francis N. Lohrenz, M.D., Marshfield ---- 236

REGULAR FEATURES

Publication Information ---------- 7

Medical Meetings ---------- 8

Letters ---------- 237

Section on Ophthalmology ---------- 239

The Medical Student Forum ---------- 240

State Medical Society ---------- 39

Physician News ---------- 47

County Societies ---------- 51

Specialty Societies ---------- 52

Paramedical/Ancillary ---------- 61

Obituaries ---------- 67

Society Records ---------- 69

Bookshelf ---------- 71

Physicians Exchange ---------- 72

Index to Advertisers ---------- 74

Wisconsin Physicians Service ---------- 75

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ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago, Illinois 60610; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin 54481.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.

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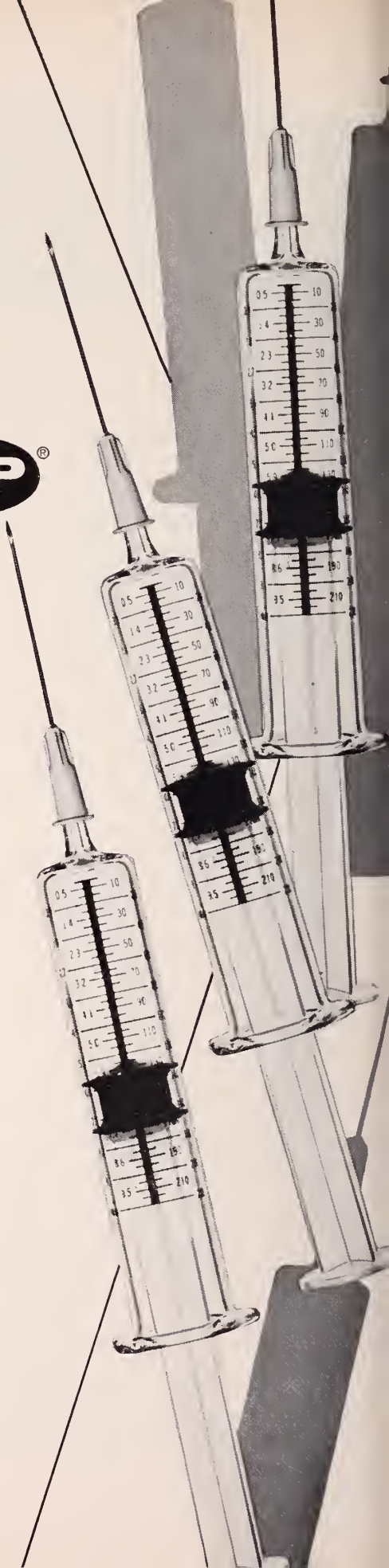

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 WISCONSIN

May 1, 8, 15, 22: Last four sessions of Cancer Nursing Course, Marquette University College of Nursing, Milwaukee.

May 9–10: Conference for Directors of Nursing in Small Hospitals, University Extension, Madison.

May 14–16: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 24: Wisconsin Alumni Day, UW, Madison.

June 7–9: Mid-year spring meeting, Wisconsin Society of Pathologists, Eagle Waters Resort, Eagle River.

June 7–9: Thirteenth annual meeting, Wisconsin State Medical Assistants Society, Milwaukee.

Sept. 12–14: Fall meeting, Wisconsin Society of Internal Medicine, Oshkosh, at The Pioneer.

Sept. 14–15 (tentative): Fall meeting, Wisconsin Otolaryngological Society.

Sept. 14–15: Fall meeting, Wisconsin Society of Anesthesiologists, Lake Geneva, at the Playboy Club.

Sept. 20–22: Fall meeting, Wisconsin Radiological Society, Lake Geneva, at the Playboy Club.

Sept. 21: Fall meeting, Wisconsin Surgical Society, St. Mary's Hospital, Madison.

Sept. 25: 1968 Wisconsin Heart Association–Adolf Gundersen Medical Foundation Symposium on Hypertension, Wisconsin State University at La Crosse.

Sept. 25–26: Annual meeting, Wisconsin Academy of General Practice, Pfister Hotel, Milwaukee.

Oct. 1–4: Sixth annual Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Oct. 5: 14th Annual Fall Cancer Conference (The Cancer Scrimmage), University of Wisconsin Medical Center, Madison.

Oct. 8–11: Meeting of the Wisconsin Nurses Association, Sheraton-Schroeder Hotel, Milwaukee.

Oct. 9–10: Meeting of Wisconsin Division, American Cancer Society, Oshkosh.

Nov. 16: Fall annual meeting of Wisconsin Society of Pathologists, Marquette School of Medicine, Milwaukee.

1968 NEIGHBORING STATES

May 2–3: Scientific sessions, Illinois Heart Association, Springfield, Ill.

May 2–4: "Prevention in Cardiology," Minnesota Heart Association and the Mayo Clinic, Rochester, Minn.

May 10–11: "Electrophysiology and Electrocardiography," Michigan Heart Association, Detroit, Mich.

June 10–14: "Internal Medicine," American College of Physicians, University of Iowa School of Medicine, Iowa City, Ia.

June 16–21: Midwest Institute of Alcohol Studies, Northwestern University, Evanston, Ill.

Sept. 26–29: "The Metabolic Basis of Heart Disease," American College of Physicians, Wayne State University School of Medicine, Detroit, Mich.

Oct. 12–18: Annual Otolaryngologic Assembly of 1968, Illinois Eye and Ear Infirmary at the Medical Center, Chicago, Ill.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

1968 OTHERS

May 2–4: Fifth Annual Meeting, American College of Clinical Pharmacology and Chemotherapy, Claridge Hotel, Atlantic City, N.J.

May 13–17: Annual meeting, Ohio State Medical Association, Cincinnati, the Netherland Hilton Hotel.

May 19–20: First International Symposium on Dextrans, co-sponsored by Texas Heart Association and others, Flagship Hotel, Galveston Island, Tex.

June 11–14: 1968 Catholic Hospital Association Convention, Philadelphia Civic Center, Pa.

June 17–20: Postgraduate course: Obstetrics and Gynecology, University of Colorado School of Medicine, Stanley Hotel, Estes Park, Colo.

June 19: Joint Session of the American College of Cardiology with the Section of Internal Medicine of the American Medical Association and the American Heart Association, AMA Annual Meeting, San Francisco, Calif.

June 26–28: Summer clinics, Children's Hospital of Denver, Vail, Colo.

June 30–July 12: Physicians Institute on Medical Aspects of Alcoholism, Rutgers—The State University, New Brunswick, N.J.

June 30–July 6: Third International Seminar and Exhibition on World Problems in Rehabilitation of the Disabled, Conference Centre, Hotel Metropole, Brighton, England.

July 8–11: Postgraduate course: Ophthalmology, University of Colorado School of Medicine, Stanley Hotel, Estes Park, Colo.

Sept. 7–11: Second International Congress of the Transplantation Society, Americana Hotel, New York City.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo.

Sept. 28–Oct. 3: Western Hemisphere Congress, International College of Surgeons, Honolulu, Hawaii.

Oct. 6–11: XVI Biennial International Congress, International College of Surgeons, Tokyo, Japan.

Oct. 9–11: 15th Western Cardiac Conference, University of Colorado Medical Center, Denver, and Colorado Heart Association.

Oct. 15–18: 51st Annual Meeting, American Dietetic Association, San Francisco, Calif.

Oct. 16–26: Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, International College of Surgeons.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

Oct. 26–Nov. 11: Around-the-World Postgraduate Clinics, International College of Surgeons, India, Egypt, Holy Land, Israel, and Greece.

Nov. 11–14: Interstate Postgraduate Medical Association Assembly, Pittsburgh, Pa.

Nov. 13–16: Forty-seventh annual convention, National Easter Seal Society for Crippled Children and Adults, Sheraton-Boston Hotel, Boston, Mass.

Nov. 19–20: 22nd Annual Meeting, American Heart Association Council on Arteriosclerosis, Bal Harbour, Fla.

Nov. 20–22: Sixtieth annual conference, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Nov. 21–24: 41st Scientific Sessions, American Heart Association, Bal Harbour, Fla.

Nov. 22–23: Psychedelic Drugs meeting, The Hahnemann Medical College and Hospital of Philadelphia, Pa.

Nov. 25–26: Annual Assembly Meeting, American Heart Association, Bal Harbour, Fla.

1969 OTHERS

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

1968 AMA

June 16–20: 117th Annual Convention, San Francisco, Calif.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Cancer Nursing Course, Milwaukee

The Milwaukee Division of the American Cancer Society, in cooperation with Marquette University College of Nursing, Milwaukee, is sponsoring a seven-week Cancer Nursing Course entitled "Looking at Cancer Together—New Days, New Ways." The first three sessions were held in April. In May the sessions will be held on Wednesdays, May 1, 8, 15, and 22. Tuition charge: $10 entire series. Classes meet from 7:30 to 9:30 p.m. at Marquette University College of Nursing, 3029 North 49th Street.

Of particular note is Session 6 on Wednesday, May 15. A community forum on cancer will be open to professionals, paramedical, nonprofessionals, and friends (no fee). Topic is "New Developments in the Diagnosis and Therapy of Cancer. What of the Future? Hopeful Aspects of Cancer." Speakers will be Dr. Anthony J. Grueninger, assistant clinical professor, of radiology, Marquette School of Medicine; and Dr. John D. Hurley, director, Cancer Clinic, St. Mary's Hospital, and fellow, American College of Surgeons.

Gundersen Symposium on Hypertension

The 1968 Wisconsin Heart Association–Adolf Gundersen Medical Foundation Symposium will cover the subject of Hypertension and will be held Sept. 25 at the Wisconsin State University in La Crosse. Further details will follow.

Institute of Alcohol Studies

A Midwest Institute of Alcohol Studies will be presented June 16–21 at Northwestern University, Evanston, Ill. Sponsors are the Illinois Department of Mental Health and Northwestern University, Michigan Department of Public Health and Western Michigan University, Ohio Department of Health and The University of Toledo, and the Wisconsin State Department of Health and Social Services and the University of Wisconsin.

The Midwest Institute of Alcohol Studies is an educational project aimed at providing basic infor-

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157. SPEECH PROBLEMS IN STROKE
Richard T. Flynn, M.D., Milwaukee
181. LABORATORY TESTS IN HYPERTENSION
Douglas D. Klink, M.D., Milwaukee
183. MULTIPLE MYELOMA, Cutaneous Manifestations
William F. Schorr, M.D., Marshfield
184. CUTANEOUS ULCERS. Treatment of
William F. Schorr, M.D., Marshfield
185. CANCER OF THE LARYNX, Role of Surgery vs. Radiology
Robert W. Edland, M.D., Madison
186. GLAUCOMA, Recognition and Management
John V. Berger, M.D., Madison
187. BRACING AND SPLINTS FOR HEMIPLEGICS
Paul A. Dudenhoefer, M.D., Milwaukee
188. PHENOL BLOCK FOR SPASTICITY
Louis L. Bensman, M.D., Milwaukee
189. SPUTUM LUNG CANCER CYTOLOGY
Stanley L. Inhorn, M.D., Madison
190. APPLICATION OF HEAT
James F. Mc Dermott, M.D., Milwaukee
191. CORONARY CARE UNIT: Pros and Cons
William Rock, M.D., Madison
192. MUMPS VACCINE
E. Richard Stiehm, M.D., Madison
193. OBSTRUCTIVE PULMONARY DISEASE: Office Diagnosis
Ross C. Kory, M.D., Milwaukee
194. OBSTRUCTIVE PULMONARY DISEASE: Office Treatment
Ross C. Kory, M.D., Milwaukee

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The Institute may provide initial information for people working full time in alcoholism programs, but it is not an advanced course in alcoholism therapy.

Individuals attending the Institute can expect to gain information that will enable them to develop better understanding and better resources for meeting alcohol-related human problems and problems of alcohol education. They can become aware of community efforts to meet the problems of alcoholism.

Total fee for the five-day institute is $85, with a $10 deposit. Further information may be obtained by contacting Albert T. Huebner, Community Program Specialist, Alcoholism Services, Room 325, State Office Building, 1 West Wilson St., Madison, Wis. 53702.

Alcoholism Institute for Physicians

A Physicians Institute on Medical Aspects of Alcoholism will be held June 30–July 12 as part of the 1968 Summer School of Alcohol Studies at Rutgers–The State University, New Brunswick, N.J. Tuition and University fees, room, and board: $325.

The etiology of alcoholism, its clinical course, typology, and complications. Treatment of the alcoholic in the intoxicated state and during the withdrawal period; long-range management of the sober alcoholic as a chronically ill person. A review of various treatment modalities such as psychotherapy, group therapy, drug therapy, aversion treatment, hypnotherapy, and psychodrama. Various approaches in program planning—outpatient, inpatient, partial hospitalization, state hospital program, general hospital participation, and specialized treatment centers. Administrative problems and the public health approach. Research on alcoholism—basic, clinical, and evaluations of treatment modalities.

Course on Psychedelic Drugs

The Hahnemann Medical College and Hospital of Philadelphia will conduct a course on Psychedelic Drugs Nov. 22–23. Directors are Drs. Paul Jay Fink and Richard E. Hicks. The course originally was scheduled for Mar. 18–20.

Transplantation Society Congress

The Second International Congress of the Transplantation Society will meet in New York City Sept. 7 through 11, at the Americana Hotel, under sponsorship by The John A. Hartford Foundation, Inc.

The scientific program of the Congress will feature, among other items, sessions on bone marrow transplantation, and cancer and pregnancy in their

relationship to transplantation. A full day will be devoted to the transplantation of organs, including kidney, heart, liver, lung and others. Body rejection of alien tissue will be covered at length.

Further information may be obtained by writing: Felix T. Rapaport, Congress Secretariat, New York University Medical Center, 560 First Avenue, New York, N.Y. 10016.

CHA Convention, Philadelphia

The 1968 Catholic Hospital Association convention will be held June 11–14 at the Philadelphia Civic Center, Pa. Theme for the meeting is "The Catholic Church in the Health Field."

Convention highlights will include topics of overall interest to hospital personnel such as "Why Church-Sponsored Health Facilities?," "Planning for Comprehensive Health Care," "Cost Controls and Quality Care," and many sectional meetings of specialized interest to department heads.

The 21st annual meeting of the Conference of Catholic Schools of Nursing will be held June 10–11 at the Bellevue Stratford Hotel, Philadelphia. The theme of this year's CCSN meeting is "National Goals in Health Care—Implications for Nursing Education."

For further details: Catholic Hospital Association, 1438 S. Grand Blvd., St. Louis, Mo. 63104.

International Congress of Gerontology

The 8th International Congress of Gerontology will be held August 24–29, 1969, in the Sheraton Park and Shoreham Hotels, Washington, D.C., and in Baltimore, Md.

The International Association of Gerontology sponsors these international congresses which are held every three years in either the United States or abroad. The Association is a federation of 34 gerontology societies from 28 countries throughout the world. The 1966 Congress was held in Vienna, Austria. The 1969 Congress will be held in Washington, D.C. under the direct sponsorship of the Gerontological Society and the American Geriatrics Society. Professor Nathan W. Shock is President of the Congress, and President Elect of the International Association of Gerontology.

Emphasis during the 8th Congress program will be on symposia, colloquia, and discussion groups where scientists and professional workers from all over the world can exchange knowledge on gerontological research and the problems of aging persons. Scientific sessions of short volunteered papers and two plenary sessions are also on the program schedule. The first plenary session will focus on the biological, psychological and social theories of aging; the second plenary session will deal with various health problems of an aging population.

Gerontologists and others working in allied fields may become active members of the Congress by payment of the registration fee of $40.00.

A definitive announcement of the Congress will be distributed in October 1968. This will provide the necessary forms and detailed information concerning submission of abstracts, applications for travel/subsistence allowances, advance registration and fees, hotel reservations, and plans for the scientific and social programs.

For further information: Secretariat, 8th International Congress of Gerontology, 9650 Rockville Pike, Bethesda, Md. 20014, USA; telephone: (301) 530–3200.

Annual Meeting of ADA

The American Dietetic Association will hold its 51st Annual Meeting in San Francisco, Calif., Oct. 15–18.

The San Francisco Hilton will be the headquarters hotel for the event. Site of the sessions and exhibition will be the Civic Auditorium—Brooks Hall.

Participants on the program are nationally recognized authorities in: nutrition, medicine, biochemistry, food industry, communications, management and education.

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MEDICAL MEETINGS *continued*

Medical Films, Color Television AMA Features

Approximately 50 medical motion pictures will be shown as part of the scientific program at the 117th Annual Convention of the American Medical Association in San Francisco, June 16–20.

Color television, presented live from a San Francisco-area medical facility, also will be featured.

The medical motion picture program will include the premiere of a new film on Diagnosis of Heart Disease, made with the sponsorship of the American College of Cardiology. Narrator of the film is Tinsley Harrison, M.D., Distinguished Professor of Medicine, University of Alabama, an internationally known authority on diagnosis of the causes of cardiac pain.

Other films to be included: Radiographic Visualization of the Biliary System and Cholecystectomy and Choledochotomy, by Dr. Frank Glenn; Bullet Embolus of the Right Ventricle, by Arthur Beall; Role of the Endometrium in Conception and Menstruation, by Dr. John Rock; and, Cold Light Endoscopy, by Norman P. Schenker of Munich, Germany, an award-winning film made in France, Germany and Austria for U.S. physicians.

Five Scientific Sections are to present programs on color television: Dermatology, case presentations; General Surgery, a surgical program including live telecast of an operation, moderated by J. Englebert Dunphy, Professor of Surgery, University of California; Laryngology, Otology and Rhinology, a program on sinus diseases; Obstetrics and Gynecology, the complete gynecologic examination; Orthopedic Surgery, spine problems in children.

The entire Scientific Program for the 1968 Annual Convention will be published in the May 6 issue of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

American College of Legal Medicine

The clinical-professional program of the American College of Legal Medicine will be held June 16 at the San Francisco Hilton Hotel in San Francisco, Calif.

Appearing on the program will be J. Harold Williams, MD, LLB, FCLM, whose subject will be "The Doctor as a Malpractice Plaintiff;" Arthur H. Coleman, MD, LLB, FCLM, "Pronouncing Death for the Heart Transplant Donor;" and David W. Louisell, LLB, "The Changing Abortion Laws—Impact on the Patient."

Robert R. Morris, MD, FCLM, and Quinn Jordan, LLB, will participate in a panel, "Is Blood a Service or Product to the Patient?" The evening banquet speaker will be James L. Goddard, MD, Commissioner of Food and Drugs, Washington, D.C.

Further details: Carl E. Wasmuth, MD, President, American College of Legal Medicine, 60 East Scott St., Suite 402, Chicago, Ill. 60610.

DR. JOHN H. HOUGHTON

Society Past President Sets Up Statewide Medical Award

Outstanding medical students in Wisconsin will be honored by the State Medical Society through an annual award recently endowed by *Dr. John H. Houghton* of Wisconsin Dells. The first award, administered by the Society's Charitable, Educational and Scientific Foundation, will be presented at the annual meeting of the Society in Milwaukee in May.

Doctor Houghton, who served as Society president in 1965–66, established the award to honor students who have scholastic excellence with an active interest in the broad social and economic responsibilities of the medical profession as a whole. In his decision to make the award, Doctor Houghton emphasized that physicians have a duty to help the student achieve a well-rounded education so that he can be called a "complete physician."

Nominations will be submitted by the deans of the two Wisconsin medical schools, with final selection by the CES Foundation.

EDITOR'S NOTE: Doctor Houghton died Mar. 25 in a Baraboo hospital following several months illness. The family has suggested memorials to the CES Foundation to augment the John H. Houghton Medical Student Award fund as explained above. An editorial, in memoriam, appears elsewhere in this issue.

COMMISSION ON SAFE TRANSPORTATION

Names Subcommittees and Organization

The Commission on Safe Transportation, created by the House of Delegates last year, met Feb. 14 at Society headquarters in Madison, with *Dr. James L. Weygandt* of Sheboygan Falls, chairman, presiding.

The Commission approved the following subcommittees and members:

ALCOHOL AND DRUGS: *Dr. Ralph Hudson*, Eau Claire, chairman; *Dr. Glenn Hillery*, Lancaster; and C. Frazier Damron, Ph.D., University of Wisconsin, Madison.

EMERGENCY CARE: *Dr. Frederick Bunkfeldt, Jr.*, Milwaukee, chairman; *Dr. Eugene E. Eckstam*, Monroe; *Dr. Walter F. Smejkal*, Manitowoc; and *Dr. Joseph D. Farrington*, Minocqua, consultant.

LICENSING STANDARDS: *Dr. James L. Weygandt*, Sheboygan Falls, chairman; *Dr. Allen W. Wittchow*, Wisconsin Rapids; *Dr. Frank L. Rundle*, Madison; John Thompson, Motor Vehicle Department, Madison; *Dr. A. L. Van Duser*, Madison; and C. Frazier Damron, Ph.D., University of Wisconsin, Madison.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY HOME DURING THE MONTH OF MARCH 1968

1 SMS Commission on Scientific Medicine
4 Legislative Advisory Committee, Wisconsin Association of Professions
4 Insurance Advisory Committee, Dane County Medical Society
5 Board of Trustees, Dane County Medical Society
5 Surgical Staff, Madison General Hospital
5 Madison Urological Society
5 Madison Anesthesiology Society
6 Planning Committee, Wisconsin Regional Medical Program
6 SMS Committee on Grievances
7 Department of Surgery, University Hospitals
7 SMS Division on School Health
8 Senior Medical Students, University of Wisconsin
8 SMS Finance Committee of Council
9 SMS Executive Committee of Council
9 Council
10 Council
10 SMS Realty Corporation
11 Madison District Association of Licensed Practical Nurses
14 Board of Directors, Wisconsin Association of Professions
15 SMS Ad Hoc Committee on The Medical Practice Act
16 SMS Commission on Medical Care Plans
17 SMS Commission on Medical Care Plans
21 SMS and UW In-Depth Scientific Teaching Program
21 Medical School Preceptors and Faculty, University of Wisconsin
22 Cancer Study Committee, Wisconsin Regional Medical Program
23 SMS Town and Gown Symposium
24 SMS Division on Nervous and Mental Diseases
25 Inter-Hospital Coordinating Disaster Committee
26 Junior Medical Students, University of Wisconsin
28 SMS Division on Alcoholism and Addiction

Meetings not held in the Society Home but which have a direct relationship are printed in italics, with the location in parentheses.

SCHOOL BUS SAFETY: *Dr. Richard C. Wixson,* Madison, chairman; Ted Sorenson, Madison, consultant; and *Dr. Clemens G. Kirchgeorg,* Neenah.

MOTORCYCLE SAFETY: John Thompson, Motor Vehicle Department, Madison; and *Dr. Walter F. Smejkal,* Manitowoc.

WATER SAFETY: *Dr. Allan J. Ryan,* Madison; and *Dr. Eugene E. Eckstam,* Monroe.

In other action the Commission recommended that the Subcommittee on Emergency Care offer its assistance and advice to Dean Van Gorden, highway safety coordinator for the State of Wisconsin, with reference to the Federal Highway Safety Act for emergency transportation of the ill and injured.

The Commission agreed that the Visual Standards Committee of the Division on Vision be invited to all Commission meetings since both groups are concerned with highway design, visual environment, and visual requirements for driver licensing.

In a discussion of legislative affairs, the Commission reaffirmed its position in support of minimum health standards for school bus drivers.

The Commission continued discussion on guidelines for the physician requested to do tests for intoxication, with further proposals planned for the next meeting.

Pioneer Medicine and the Museum Featured in Television Program

Wisconsin children in grades 4 to 6 will learn more about pioneer medicine, the Museum of Medical Progress and Stovall Hall of Health when WHA-TV presents an educational program, "When Our State Was Young," May 15 on Channel 21.

The program is included in the "Wisconsin School of the Air." The first showing will start at 10:40 a.m. and will be repeated at 1:30 p.m.

The pioneer medicine portion of the program was filmed last fall by WHA-TV in cooperation with the State Historical Society and the State Medical Society of Wisconsin.

The Museum, now in its seventh year of operation, opened April 15 and will close October 31. Tourist hours are from 9:00 a.m. to 5:00 p.m. daily. From July 4 through Labor Day, the Museum also will be open in the evenings until 9:00 p.m.

New Telephone Number for Society

Effective May 4, if everything goes well, the State Medical Society of Wisconsin will have a new telephone number and it will be just one number for all calls: (area code 608) 257–6781. A completely new telephone system has been installed. Further announcement about the new number appears on page 41 of this issue.

AMERICAN ACADEMY OF PEDIATRICS CAUTIONS AGAINST UNNECESSARY PUBLIC WARNINGS FOR VACCINES

The American Academy of Pediatrics has cautioned against "undue emphasis" in requiring public warnings regarding isolated complications or hazards which might result from use of vaccines in mass immunization programs.

Such warnings, the Academy pointed out, "would adversely affect the health of the public by unwarrantably diminishing participation in these programs."

The AAP Executive Board, meeting here during the organization's spring session at the Regency Hyatt House, expressed its concern over a recent court decision imposing liability on a drug manufacturer for not warning the public participating in a mass immunization program about remote risks involved in receiving oral poliovirus vaccine.

The Board strongly endorsed recommendations set forth by the Academy's Committee on Control of Infectious Diseases concerning the recent two-to-one decision of the United States Court of Appeals for the Ninth Circuit in the case of Davis vs. Wyeth Laboratories, Inc., Jan 22, 1968.

Emphasizing the possible implications of this decision upon important public health programs, the Academy, in its statement, pointed to several types of immunization programs that would be affected by the court decision, including those currently administered by schools, public health departments, community health programs such as Head Start, and others.

"The decision may have deleterious effects both on the conduct of, and public participation in, efforts directed against many other infectious diseases such as measles, diphtheria, whooping cough, tetanus, and others," the AAP's statement cautioned. "In the opinion of the AAP Committee on Control of Infectious Diseases, the benefits of these programs are tremendous."

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- Regional (Field) Services
- CES Foundation
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- WPS Medicare-Plus $15,000 (supplemental coverage to federal medicare)

TITLE XVIII (MEDICARE) and TITLE XIX (MEDICAID)

- Claims on Social Security Medicare—Part B
- Payments for MD charges
- Claims on Title XIX (Wisconsin Medical Assistance Program)

MILITARY MEDICARE (CHAMPUS)

- Claims for dependents of servicemen
- Claims for retired military servicemen

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1968 ANNUAL MEETING PROGRAM by SPECIALTY
STATE MEDICAL SOCIETY OF WISCONSIN • MAY 14–16 • MILWAUKEE

ALLERGY

WEDNESDAY LUNCHEON, MAY 15

12:30—Hotel Sheraton–Schroeder

ALLERGIC DERMATOLOGIC MANIFESTATIONS OF ARTHROPOD EXPOSURE
Frank Perlman, MD, Portland

WEDNESDAY AFTERNOON, MAY 15

2:00—Walker Hall, Milwaukee Auditorium

EFFECTS OF NEBULIZED MEDICATION IN TREATMENT OF ASTHMA AND CHRONIC BRONCHOPULMONARY DISEASES
Frank Perlman, MD, Portland
Clinical Professor of Medicine and Chief of the Division of Immunology, Allergy and Infectious Diseases, University of Oregon Medical School

RECENT OBSERVATIONS OF PIGEON BREEDER'S DISEASE
Abe Sosman, MD, Milwaukee
Assistant Professor of Internal Medicine and Allergy, Marquette School of Medicine

ROUNDTABLE DISCUSSION: THE USE AND ABUSE OF NEBULIZED MEDICATION
David M. Glassner, MD, Milwaukee
Moderator
Frank Perlman, MD, Portland
Richard Paul Jahn, MD, Milwaukee

CASE PRESENTATIONS: DIRE EFFECTS OF ABUSIVE SELF-ADMINISTERED NEBULIZED MEDICATION
David M. Glassner, MD, Milwaukee

ANESTHESIOLOGY

THURSDAY LUNCHEON, MAY 16

12:30—Hotel Sheraton–Schroeder

THE PACEMAKER PATIENT: WILL THE CAUTERY TURN HIM OFF?
John M. R. Bruner, MD, Boston

THURSDAY AFTERNOON, MAY 16

2:00—South Kilbourn Hall, Milwaukee Auditorium

ELECTRICAL HAZARDS IN HOSPITALS
John M. R. Bruner, MD, Boston
Assistant in Anesthesia, Massachusetts General Hospital and Harvard Medical School

PRESENT STATUS OF ELECTRO-ANESTHESIA
Anthony Sances, PhD, Milwaukee
Associate Professor of Neurosurgery, Associate Professor and Director of Biomedical Engineering, Marquette University and Marquette School of Medicine

PANEL
Frederick D. Cook, MD, Green Bay
Moderator
John M. R. Bruner, MD, Boston
Anthony Sances, PhD, Milwaukee

COMPUTERS IN MEDICINE

WEDNESDAY MORNING, MAY 15

9:30—Juneau Hall, Milwaukee Auditorium

USE OF COMPUTERS IN MEDICINE
C. Daniel Giesler, ScD, Madison
Associate Professor of Electrical Engineering, University of Wisconsin
Moderator
G. Phillip Hicks, PhD, Madison
Assistant Professor of Medicine, University of Wisconsin Medical School
Vincent C. Rideout, MS, Madison
Professor of Electrical Engineering, University of Wisconsin
Warner V. Slack, MD, Madison
Assistant Professor of Medicine and Professor of Computer Science, University of Wisconsin

PROMISING NEW DEVICES FOR USE IN MEDICINE
John G. Webster, PhD, Madison
Assistant Professor of Electrical Engineering and Instrumentation Systems, University of Wisconsin
Moderator
Edwin N. Lightfoot, PhD, Madison
Professor of Chemical Engineering, University of Wisconsin
John W. Mitchell, PhD, Madison
Associate Professor of Mechanical Engineering, University of Wisconsin
Stuart J. Updike, MD, Madison
Instructor in Medicine, University of Wisconsin

DERMATOLOGY

WEDNESDAY LUNCHEON, MAY 15

12:30—Hotel Sheraton–Schroeder

TREATMENT OF COMMON SKIN DISEASES
Arthur C. Curtis, MD, Ann Arbor

WEDNESDAY AFTERNOON, MAY 15

2:00—North Kilbourn Hall, Milwaukee Auditorium

COLLAGEN DISEASE AS SEEN BY THE DERMATOLOGIST
Arthur C. Curtis, MD, Ann Arbor
Professor of Dermatology, University of Michigan Medical School

DERMATOLOGY—*continued next page*

DERMATOLOGY *continued*

SKIN DISEASES AGGRAVATED BY SUNLIGHT
Derek J. Cripps, MD, Madison
Assistant Professor of Dermatology, University of Wisconsin Medical School

PANEL
James W. Bringe, MD, Sheboygan
Moderator
Arthur C. Curtis, MD, Ann Arbor
Derek J. Cripps, MD, Madison
Charles E. Reed, MD, Madison

INTERNAL MEDICINE

TUESDAY MORNING, MAY 14

9:30—Juneau Hall, Milwaukee Auditorium

THE EFFECT OF AGE AND POSTMENOPAUSAL OSTEOPOROSIS ON THE INTESTINAL ABSORPTION OF CALCIUM
Louis V. Avioli, MD, St. Louis
Assistant Professor of Medicine, Washington University School of Medicine

FACTORS INVOLVED IN THE DEVELOPMENT OF OSTEOPOROSIS
Robert P. Heaney, MD, Omaha
Professor and Chairman, Department of Medicine, Creighton University School of Medicine

PANEL
Edgar S. Gordon, MD, Madison
Moderator
Louis V. Avioli, MD, St. Louis
Robert P. Heaney, MD, Omaha

TUESDAY LUNCHEONS, MAY 14

12:30—Hotel Sheraton–Schroeder

THE DIFFERENTIAL DIAGNOSIS OF HYPERCALCEMIA
Louis V. Avioli, MD, St. Louis
Assistant Professor of Medicine, Washington University School of Medicine

MANAGEMENT OF THE PATIENT WITH SARCOIDOSIS
Benjamin Burrows, MD, Chicago

DIAGNOSIS AND TREATMENT OF METABOLIC BONE DISEASE
Robert P. Heaney, MD, Omaha
Professor and Chairman, Department of Medicine, Creighton University School of Medicine

PHILOSOPHY OF RESPIRATORY CARE
Thomas L. Petty, MD, Denver

TUESDAY AFTERNOON, MAY 14

2:00—Juneau Hall, Milwaukee Auditorium

THE NATURAL HISTORY AND PROGNOSIS OF OBSTRUCTIVE EMPHYSEMA
Benjamin Burrows, MD, Chicago
Professor of Medicine, University of Chicago School of Medicine

PULMONARY REHABILITATION
Thomas L. Petty, MD, Denver
Assistant Professor of Medicine, University of Colorado School of Medicine

PANEL
John Rankin, MD, Madison
Moderator
Benjamin Burrows, MD, Chicago
Thomas L. Petty, MD, Denver
Helen A. Diekie, MD, Madison

WEDNESDAY LUNCHEONS, MAY 15

12:30—Hotel Sheraton–Schroeder

BIOMEDICAL ENGINEERING RESEARCH
C. Daniel Geisler, SeD, Madison
Associate Professor of Electrical Engineering, University of Wisconsin

SOME PRACTICAL APPROACHES TO GERIATRIC PROBLEMS
William S. Middleton, MD, Madison
Professor of Medicine Emeritus, Dean of Medicine Emeritus, University of Wisconsin Medical School

BIOMEDICAL INSTRUMENTATION
John G. Webster, PhD, Madison
Assistant Professor of Electrical Engineering and Instrumentation Systems, University of Wisconsin

THURSDAY LUNCHEONS, MAY 16

12:30—Hotel Sheraton–Schroeder

HEADACHES
J. D. Kabler, MD, Madison
Associate Professor of Medicine, University of Wisconsin Medical School

NEWER DRUGS AND THEIR USES
Ovid O. Meyer, MD, Madison
Professor of Medicine, University of Wisconsin Medical School

NEW DRUGS AND THE TREATMENT OF VIRUS INFECTIONS
June E. Osborn, MD, Madison
Assistant Professor of Pediatrics, University of Wisconsin Medical School

ENGINEERING IN MEDICINE AND BIOLOGY
Anthony Sanees, PhD, Milwaukee
Associate Professor of Neurosurgery, Associate Professor and Director of Biomedical Engineering, Marquette University and Marquette School of Medicine

SEMINAR ON THE KIDNEY

THURSDAY ALL DAY, MAY 16

8:00 to 4:30—Pere Marquette Room, Hotel Sheraton–Schroeder

Robert O. Burns, MD, Madison
Associate Professor of Medicine, University of Wisconsin Medical School
Chairman

Richard E. Rieselbach, MD, Madison
Assistant Professor of Medicine, University of Wisconsin Medical School

Carl W. Trygstad, MD, Madison
Post-doctoral Fellow, Department of Pediatrics, University of Wisconsin Medical School

Special in-depth teaching program covering physiology, pathology, and diseases of clinical interest. Limited to 30 physicians. Advance registration and confirmation required.

NEUROLOGY

WEDNESDAY LUNCHEON, MAY 15

12:30—Hotel Sheraton–Schroeder

FITS, FAKIRS AND FAKERS
J. Preston Robb, MD, Montreal, Canada

WEDNESDAY AFTERNOON, MAY 15

2:00—South Kilbourn Hall, Milwaukee Auditorium

CLINICAL DIAGNOSIS OF EPILEPSY
J. Preston Robb, MD, Montreal, Canada
Associate Professor of Neurology and Neurosurgery, McGill University Faculty of Medicine

ROLE OF ELECTROENCEPHALOGRAPHY IN THE DIAGNOSIS OF EPILEPSY
Francis M. Kruse, MD, Marshfield
Assistant Clinical Professor of Neurology, University of Wisconsin

NEUROPSYCHOLOGICAL EVALUATION OF THE EPILEPTIC PATIENT
Hallgrim Klove, PhD, Madison
Associate Professor of Neurology, Director, Neuro–Psychology Laboratory, Department of Neurology, University of Wisconsin Medical School

MEDICAL MANAGEMENT OF EPILEPSY
Philip T. White, MD, Milwaukee
Professor and Chairman, Department of Neurology, Marquette School of Medicine

SURGICAL MANAGEMENT OF THE EPILEPTIC
Flavio Puletti, MD, Madison
Associate Professor of Neurosurgery, University of Wisconsin Medical School

CONDITIONING IN CERTAIN CASES OF EPILEPSY
Francis M. Forster, MD, Madison
Professor and Chairman, Department of Neurology, University of Wisconsin Medical School

THE PHYSICIAN'S ROLE IN HANDLING THE SOCIAL IMPLICATIONS OF EPILEPSY
Jean P. Davis, MD, Milwaukee
Milwaukee Medical Clinic

OBSTETRICS AND GYNECOLOGY

TUESDAY LUNCHEONS, MAY 14

12:30—Hotel Sheraton–Schroeder

CHROMOSOMAL ASPECTS OF PREGNANCY
David Yi-Yung Hsia, MD, Chicago

URETHRAL SUSPENSION
Richard F. Mattingly, MD, Milwaukee
Professor and Chairman, Department of Obstetrics and Gynecology, Marquette School of Medicine

CLOMID—ONE YEAR LATER
Gloria E. Sarto, MD, Madison
Associate Professor of Gynecology and Obstetrics, University of Wisconsin Medical School

TUESDAY AFTERNOON, MAY 14

2:00—South Kilbourn Hall, Milwaukee Auditorium

GAMMA GLOBULIN IN THE PREVENTION OF Rh. ISO-IMMUNIZATION
Serafeim P. Masouredis, MD, Milwaukee
Executive Director, Milwaukee Blood Center, Inc.

GENETIC FACTORS IN PREGNANCY WASTAGE
David Yi-Yung Hsia, MD, Chicago
Professor of Pediatrics, Northwestern University Medical School

OUR RESPONSIBILITY IN THE DEFINITION OF PATTERNS IN MATERNAL AND NEWBORN CARE
Ben M. Peckham, MD, Madison
Professor and Chairman, Department of Gynecology and Obstetrics, University of Wisconsin Medical School

PANEL
Joseph C. Fralich, MD, Racine
Moderator
David Yi-Yung Hsia, MD, Chicago
Ben M. Peckham, MD, Madison

WEDNESDAY LUNCHEON, MAY 15

12:30—Hotel Sheraton–Schroeder

VASCULAR PROBLEMS ASSOCIATED WITH PREGNANCY
Richard D. Sautter, MD, Marshfield

OPHTHALMOLOGY

THURSDAY MORNING, MAY 16

9:00–12:00—East Room, Hotel Sheraton–Schroeder

CLINIC ON APPLANATION TONOMETRY
Richard O. Schultz, MD, Milwaukee
Associate Professor and Chairman, Department of Ophthalmology, Marquette School of Medicine
Chairman

9:00–10:30 & 10:30–12:00—English Room, Hotel Sheraton–Schroeder

TWO SHOWINGS OF A ONE AND ONE-HALF HOUR MOVIE PROGRAM
Gordon L. Backer, MD, Wausau
Film Selector

9:00–12:00—Fifth Floor Lobby, Hotel Sheraton–Schroeder

STEREO-PHOTOGRAPHIC EXHIBIT
Ophthalmology Division, University of Wisconsin Medical School

THURSDAY NOON, MAY 16

12:00–2:00—East Room, Hotel Sheraton–Schroeder

SPECIAL LUNCHEON: SECTIONS ON OPHTHALMOLOGY AND OTOLARYNGOLOGY
Co-chairmen: *James V. Bolger, MD, Milwaukee*, Chairman, Section on Ophthalmology; and *John K. Scott, MD, Madison*, Chairman, Section on Otolaryngology

BUSINESS MEETING: SECTION ON OPHTHALMOLOGY

OPHTHALMOLOGY—*continued next page*

OPHTHALMOLOGY *continued*

THURSDAY AFTERNOON, MAY 16

2:00—East Room, Hotel Sheraton–Schroeder

RECENT ADVANCES IN SERONEGATIVE OCULAR SYPHILIS

J. Lawton Smith, MD, Coral Gables
Associate Professor of Ophthalmology and Neurosurgery and Assistant Professor of Neurology, University of Miami School of Medicine, Fla.

CLINICO-PATHOLOGICAL CONFERENCE

Harry Easom, MD, Milwaukee
Assistant Clinical Professor, Department of Ophthalmology, Marquette School of Medicine

Guillermo de Venecia, MD, Madison
Assistant Professor of Surgery (Ophthalmology) University of Wisconsin Medical School

Moderators

THURSDAY EVENING, MAY 16

6:30—University Club

DINNER PROGRAM: SECTION ON OPHTHALMOLOGY

William H. Bennett, MD, Racine
President, Milwaukee Ophthalmic Society
Chairman

SPEAKER: *J. Lawton Smith, MD, Coral Gables*

SOME NEURO-OPHTHALMOLOGIC MOTILITY PROBLEMS

FRIDAY MORNING, MAY 17

9:00–12:00—Milwaukee County General Hospital, King Conference Room

CLINICAL ROUNDS

J. Lawton Smith, MD, Coral Gables
Visiting Professor in Ophthalmology

ORTHOPEDICS

THURSDAY LUNCHEON, MAY 16

12:30—Hotel Sheraton–Schroeder

SURGERY OF ARTHRITIS CONDITIONS

Hampar Kelikian, MD, Chicago

THURSDAY AFTERNOON, MAY 16

2:00—Walker Hall, Milwaukee Auditorium

HALLUX VALGUS AND ALLIED PROBLEMS OF THE FOREFOOT

Hampar Kelikian, MD, Chicago
Professor Emeritus, Northwestern University School of Medicine

IMMEDIATE POSTOPERATIVE FITTING OF AMPUTEES

Alfred E. Kritter, MD, Waukesha
Assistant Clinical Professor, Marquette School of Medicine

THURSDAY EVENING, MAY 16

6:30—Milwaukee Athletic Club

DINNER: WISCONSIN ORTHOPAEDIC SOCIETY
SPEAKER: *Hampar Kelikian, MD, Chicago*
CONGENITAL MALFORMATIONS OF THE HAND

OTOLARYNGOLOGY

THURSDAY MORNING, MAY 16

9:30—Juneau Hall, Milwaukee Auditorium

AN OTOLARYNGOLOGIST'S APPROACH TO FACIAL FRACTURES

Willis G. McMillan, MD, Madison
Clinical Instructor, Department of Otolaryngology; Attending Staff, V. A. Hospital

A SURGICAL APPROACH TO DEAFNESS

Michael M. Paparella, MD, Minneapolis

PANEL: A GROUP APPROACH TO HEARING AND SPEECH PROBLEMS IN CHILDREN

Maxine Bennett, MD, Madison
Professor of Surgery and Chairman, Division of Otolaryngology, University of Wisconsin Medical School

Moderator

Michael M. Paparella, MD, Minneapolis

Stanley Ewanowski, PhD, Madison
Assistant Professor, Rehabilitation Medicine, Assistant Professor, Department of Communicative Disorders

Charles Tait, PhD, Madison
Assistant Professor, Department of Communicative Disorders

THURSDAY NOON, MAY 16

12:00–2:00—East Room, Hotel Sheraton–Schroeder

SPECIAL LUNCHEON: SECTIONS ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Co-chairmen: *James V. Bolger, MD, Milwaukee*, Chairman, Section on Ophthalmology; and *John K. Scott, MD, Madison*, Chairman, Section on Otolaryngology

THURSDAY AFTERNOON, MAY 16

2:00—Juneau Hall, Milwaukee Auditorium

PATHOLOGY AND TREATMENT OF CHRONIC EAR DISEASE

Michael M. Paparella, MD, Minneapolis
Professor and Chairman, Department of Otorhinolaryngology, University of Minnesota School of Medicine

BUSINESS MEETING: WISCONSIN OTOLARYNGOLOGICAL SOCIETY

RESIDENT–INTERN PROGRAM

THURSDAY MORNING, MAY 16

10:00—South Kilbourn Hall, Milwaukee Auditorium
(Details appeared in the March issue)

PEDIATRICS

WEDNESDAY LUNCHEON, MAY 15

12:30—Hotel Sheraton–Schroeder

IMMUNIZATIONS: PAST, PRESENT AND FUTURE
Vincent A. Fulginiti, MD, Denver

WEDNESDAY AFTERNOON, MAY 15

2:00—Juneau Hall, Milwaukee Auditorium

THE INVESTIGATION AND TREATMENT OF GROWTH DISORDERS IN CHILDREN
George R. Kerr, MD, Madison
Assistant Professor of Pediatrics, University of Wisconsin Medical School

QUESTION AND ANSWER PERIOD

PEPTIC ULCER IN CHILDREN, A FAMILIAL DISEASE
Frederic M. Blodgett, MD, Milwaukee
Professor of Pediatrics, Marquette School of Medicine

A NEW LOOK AT IMMUNOLOGIC DEFICIENCY DISEASES
Vincent A. Fulginiti, MD, Denver
Associate Professor of Pediatrics, University of Colorado Medical Center

QUESTION AND ANSWER PERIOD
Vincent A. Fulginiti, MD, Denver
George A. Kerr, MD, Madison
Frederic M. Blodgett, MD, Milwaukee

RADIOLOGY

TUESDAY LUNCHEONS, MAY 14

12:30—Hotel Sheraton–Schroeder

CERVICAL SPONDYLOSIS
William N. Hanafee, MD, Los Angeles

ASEPTIC NECROSIS OF BONE
William Martel, MD, Ann Arbor

TUESDAY AFTERNOON, MAY 14

2:00—North Kilbourn Hall, Milwaukee Auditorium

SELECTIVE ANGIOGRAPHY IN THE HEAD AND NECK
William N. Hanafee, MD, Los Angeles
Professor and Chairman, Department of Radiology, University of California School of Medicine

SPONDYLITIS OF RHEUMATOID ARTHRITIS
William Martel, MD, Ann Arbor
Professor of Radiology, University of Michigan Medical Center

PANEL
Andrew B. Crummy, Jr., MD, Madison
Moderator
William N. Hanafee, MD, Los Angeles
William Martel, MD, Ann Arbor
John H. Juhl, MD, Madison
Morris B. Glover, MD, Madison

TUESDAY EVENING, MAY 14

6:30—Milwaukee Yacht Club

DINNER, WISCONSIN RADIOLOGICAL SOCIETY
MEMBERS ONLY. $6.25 per person. Reservations to Harold F. Ibach, MD, 2400 West Villard Ave., Milwaukee, Wis. 53209

SPEAKER: *William Martel, MD, Ann Arbor*
"Practical Points in the Diagnosis of Joint Diseases"

SURGERY

THURSDAY MORNING, MAY 16

8:00–12:00—Veterans Administration Hospital, Wood

WET CLINIC
Ben R. Lawton, MD, Marshfield
Moderator

(Nonmember guests welcome)

THURSDAY LUNCHEON, MAY 16

12:30—Hotel Sheraton–Schroeder

WHITHER HEART TRANSPLANTATION?
John S. Najarian, MD, Minneapolis

THURSDAY AFTERNOON, MAY 16

1:45—North Kilbourn Hall, Milwaukee Auditorium

ULCERATIVE COLITIS AND CARCINOMA
William B. Gallagher, MD, La Crosse

CONGENITAL ANOMALIES OF THE THORACIC DUCT
Albert H. Pemberton, MD, Milwaukee
Associate Clinical Professor of Thoracic and Cardiovascular Surgery, Marquette School of Medicine

THE EFFECTS OF A NEW ANTIGASTRIN COMPOUND ON HYPERSECRETION IN THE DOG
Kenneth R. Tucker, MD, Milwaukee
Stuart D. Wilson, MD, Milwaukee

PANEL: "MEET THE CHIEF"—SHARP DISECTION OF THE ANATOMY AND PATHOLOGY OF MODERN SURGICAL EDUCATION
Albert G. Martin, MD, Milwaukee
Moderator
Anthony R. Curreri, MD, Madison
Chief of Surgery, University of Wisconsin Medical School
Edwin H. Ellison, MD, Milwaukee
Chief of Surgery, Marquette School of Medicine
John S. Najarian, MD, Minneapolis
Chief of Surgery, University of Minnesota School of Medicine

ADDRESS OF INCOMING PRESIDENT
John T. Mendenhall, MD, Madison
Professor of Surgery, University of Wisconsin Medical School

THURSDAY EVENING, MAY 16

6:30—Milwaukee Athletic Club, Milano Room

DINNER: WISCONSIN SURGICAL SOCIETY
Members and guests with wives

SPEAKER: *Senator Gaylord Nelson*

Dr. Sickels Returns to Clinic

Dr. William F. Sickels, Menasha, recently returned to the Riverside Clinic after serving as a captain in the United States Army Medical Corps. Doctor Sickels graduated from Northwestern University School of Medicine, interned at Wesley Memorial Hospital in Chicago, and completed his residency as a fellow in Internal Medicine at the Mayo Clinic, Rochester. He was associated with the clinic before entering service in March 1966.

Dr. Ambrose Renamed to Commission

Dr. Stephen H. Ambrose, Whitewater, recently was renamed to his post on the Whitewater Medical Commission.

Dr. Larson Reelected to AAGP

Dr. Harry H. Larson, Ashland, recently was reelected to active membership in the American Academy of General Practice.

Dr. Gundersen Guest Speaker

Dr. A. Erik Gundersen, La Crosse, recently spoke at a meeting of the La Crosse Chapter of Catholic Nurses. Doctor Gundersen spoke on "Risk Factors in Heart Disease."

Dr. Wilkinson Heads Cancer Crusade

Dr. John D. Wilkinson, Oconomowoc, recently was selected to head the 1968 Oconomowoc area annual American Cancer Society crusade. The announcement was made by Dr. Daniel Miller, president of the Oconomowoc branch of the American Cancer Society. Doctor Wilkinson has been serving the Oconomowoc community and surrounding areas since 1929.

Dr. Bardenwerper Reelected to AAGP

Dr. H. W. Bardenwerper, Waterford, recently was reelected to active membership in the American Academy of General Practice.

Dr. Tuchman Guest Speaker

Dr. Herman Tuchman, Milwaukee, chief of medicine at St. Michael's hospital, recently was the guest speaker at a service recognition luncheon held at the hospital. Doctor Tuchman spoke on the hospital's intensive coronary care unit.

Guest Speakers at Milwaukee Conference

Milwaukee's medical complex, pornography, and international understanding were the subjects discussed at a meeting held recently at the YWCA. Speakers included in the symposium were *Drs. John R. Petersen*, director of medical services for Milwaukee County; *Charles W. Landis*, county director of mental health; and *Gerald A. Kerrigan*, dean of the Marquette School of Medicine.

Dr. Zupanc Guest Speaker

Dr. Edward A. Zupanc, Monroe, recently was the guest speaker at the meeting of the Monroe Jaycettes. Doctor Zupanc, a pediatrician, discussed child behavior problems.

Dr. Ansfield Addresses Nurses Association

Dr. Fred J. Ansfield, Madison, recently was the guest speaker before the Kenosha District Nurses Association. Doctor Ansfield, professor of Clinical Oncology at the University of Wisconsin Medical School, spoke on "New Trends in Cancer Research." He has contributed over 50 articles on his research to professional publications and is a past president of The American Society of Clinical Oncology.

Dr. Davidoff Appointed Chief of Surgery

Dr. David E. Davidoff, Milwaukee, recently was appointed chief-of-surgery at Doctors Hospital. Doctor Davidoff received his medical degree from Washington University, St. Louis, Mo., and served his internship and residency in surgery at Beth Israel Hospital, Boston, Mass. He is a fellow of the American College of Surgeons.

Dr. Kurzon Guest Speaker

Dr. Alvin M. Kurzon, Milwaukee, recently was the guest speaker before the Mequon Community Methodist Church. The subject of his speech was on sex education of children and youth.

Doctors Participate in Panel Discussion

Drs. Gerald Kerrigan, dean of the Marquette School of Medicine, and John Petersen, medical director of County General hospital, recently participated in a panel discussion of the future of Milwaukee's medical center. Dr. Philip T. White, chairman of the Department of Neurology, Marquette School of Medicine, was the moderator. The discussion was held before the annual dinner meeting of the Multiple Sclerosis Society.

Dr. Kief Guest Speaker

Dr. H. J. Kief, Fond du Lac, recently spoke before the Fond du Lac County Federation of Republican Women. Doctor Kief, city health officer and a member of the newly formed Board of the Wisconsin Department of Health and Social Services, spoke on the reorganization of the executive branch of the Wisconsin state government; the reorganization within a specific board of the executive branch, and on the special interest of the medical profession in

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Physicians whose names appear in italics are members of the State Medical Society.

nonpartisan politics. Doctor Kief is past president of the Fond du Lac County Medical Society and current president of the State Medical Society of Wisconsin.

Dr. Stewart Participates in IMA Program

Dr. Richard D. Stewart, associate professor and chairman of the Department of Environmental Medicine at Marquette School of Medicine, Milwaukee, recently participated in the American Industrial Health Conference held in San Francisco, Calif.

Dr. Peterson to Be ACOG Fellow

Dr. Jack A. Peterson, Waukesha, will be installed as a fellow of the American College of Obstetricians and Gynecologists at its annual meeting, May 6–9, in Chicago.

Dr. Sciarra Guest Speaker

Dr. P. A. Sciarra, Sheboygan, recently spoke on "Cigarette Smoking, A Hazard" before the members of the Wilson School Parent–Teacher Association.

Dr. Thomas Guest Speaker

Dr. Preston Thomas, Milwaukee, recently spoke before the Woman's Club of West Allis. Doctor Thomas, medical director of the Sacred Heart Rehabilitation Hospital, gave as his topic "Is Your Age Showing."

Dr. Falk Guest Speaker

Dr. V. S. Falk, Jr., Edgerton, recently was the guest speaker before the Stoughton Lions Club "Ladies Night" meeting. Doctor Falk, medical editor of the WISCONSIN MEDICAL JOURNAL, has recently returned from his second tour of duty as a volunteer physician in Vietnam.

Dr. Hutson Attends Meeting

Dr. Clare F. Hutson, Madison, attended the annual meeting of the New Orleans Academy of Ophthalmology. A symposium on Retinal Detachment and Retinal Detachment Surgery was a part of the program.

Dr. Treffert Guest Speaker

Dr. Darold A. Treffert, superintendent of Winnebago State Hospital and medical director of Dodge County Guidance Clinic, Juneau, recently spoke on "Sex Education for Children" at the Little Theater of the Horicon High School.

Doctors Participate at Clinic

Drs. William V. Dovenbarger and *Fred W. Fletcher*, Marshfield Clinic, and Dr. W. J. Johnson, Withee, will assist at a group therapy clinic on a "Five-Day Plan to Stop Smoking" which will be held at the Marshfield Convalescent Center in May. The first session was held at the Center in February.

Dr. Balistrieri Speaks to Rotary Club

Dr. James J. Balistrieri, director of adolescent service at Milwaukee County Hospital, recently spoke before the West Allis Rotary Club. His topic was "Are Hippies Necessary?"

Dr. Shahidi Attends Meeting

Dr. Nasrollah T. Shahidi of the University of Wisconsin Medical School, Madison, recently attended a meeting of the New York Academy of Science. Doctor Shahidi described some of the effects that over-the-counter medicines can have on susceptible individuals in the way of blood-cell destruction.

Dr. Ellison Elected President

Dr. Edwin H. Ellison, professor and chairman, Department of Surgery, Marquette School of Medicine, Milwaukee, was elected president of the Central Surgical Association at its 25th Anniversary meeting in Cleveland, Ohio. From 1964 to 1967, Doctor Ellison served as secretary of the organization.

Dr. Roberts Board Certified

Dr. R. Wm. Roberts, Oshkosh, recently was certified by The American Board of Urology. He is associated in practice with *Dr. Earl F. Cummings*, Oshkosh.

Dr. Bennett Joins Clinic

Dr. Paul Bennett, formerly of Galveston, Tex., recently joined the staff of the Beloit Clinic. Doctor Bennett graduated from Northwestern University Medical School in 1960 and completed his internship at the University of Texas Medical Branch at Galveston. He served his residency at the University of Texas and was an Army physician, stationed in Alaska.

Dr. Koch Elected to Cancer Board

Dr. James W. Koch, Colby, recently was elected to the board of directors of the Clark County Cancer Crusade.

Dr. Pesarillo at Arcadia

Dr. Servando Pesarillo, Chicago, recently arrived in Arcadia to assist *Dr. Thomas P. Chisholm* on the staffs of the Arcadia Medical Clinic and St. Joseph's Hospital. Doctor Pesarillo graduated from Manila Central University and interned at St. Joseph's Hospital, London, Ontario, Canada. He completed his residency at Belmont Community, American, and Martha Washington hospitals, Chicago.

Two Become ACC Fellows

Drs. Robin N. Allin and *A. J. Richtsmeier*, Madison, recently were made fellows in the American College of Cardiology. Dr. Christian Barnard, noted heart transplant specialist, was also given a fellowship by the organization and spoke to the cardiologists on his experiences with transplants.

Dr. Bannister Elected to AAGP

Dr. Frederick M. Bannister, Chetek, recently was elected to active membership in the American Academy of General Practice.

Deaconess Hospital Staff Heads Reappointed

All Deaconess Hospital medical staff department heads have been reappointed to serve in 1968. They are: *Drs. Richard P. Jahn*, Brookfield, chief-of-staff; *James W. Fulton*, Wauwatosa, chief of the department of general practice; *Albino L. Settimi*, Elm Grove, chief of the department of medicine; *George S. Woodward*, Wauwatosa, chief of the department of obstetrics and gynecology; and *Richard E. Zellmer*, Elm Grove, chief of the department of special services. *Dr. Benjamin G. Narodick*, Whitefish Bay, will continue as chief of the department of surgery.

Antigo Medical Center Completed

Four Antigo physicians moved into the new Antigo Medical Center in April. They are: *Dr. Earl J. Roth*, general surgeon; *Dr. Robert W. Cromer* and *Dr. John E. Garritty*, general practitioners, and *Dr. William P. Curran*, general practitioner with subspecialty in general surgery and orthopedics. The new medical facility is designed for eight physicians and additional doctors are expected to join the present staff in the future.

Former Beloit Pediatrician Featured

Dr. Frank K. Johnson, a former pediatrician in Beloit, was featured in the JANESVILLE GAZETTE Feb. 9 for having switched his medical specialty to psychiatry after 18 years of pediatric practice at the Beloit Clinic. While the transition is uncommon for physicians at the age of 50, the GAZETTE points out, it does show the versatility and opportunities available to physicians.

The article emphasizes Doctor Johnson's belief that the emotional problems of his patients are inseparable from their physical ailments and thus psychiatry and pediatrics blend well for giving optimal patient care. Doctor Johnson has a year and a half left of his residency at the University of Wisconsin Medical School. He goes to Janesville one day a week as a resident psychiatrist in training at the Rock County Guidance Clinic.

Doctor Najaf to Serve Cashton

Dr. Moktar Najaf (formerly Najafzadeh), who was medical director of the McCoy Job Corps Center before it closed, has arranged to serve the residents of Cashton and the surrounding area in addition to his practice in Sparta. He will use the office of the late Dr. N. M. Mauel. Doctor Najaf will continue to live and practice in Sparta where he opened a clinic last November.

Dr. George Gersch Resumes Practice

Dr. George P. Gersch resumed his medical practice in West Salem March 1 after two years in military service, including duty in Vietnam.

Otomobile Testing Unit

A DIAGNOSTIC OTOLOGICAL CLINIC under the auspices of the Bureau for Handicapped Children of the State Department of Public Instruction was conducted recently in Manitowoc. Examinations took place in the new otomobile which contains examining room, soundproof room, and waiting room for parents. Dr. D. K. Shahrokh of Fond du Lac is shown checking a first-grade student. Objective of the program is to evaluate and diagnose hearing problems of those children who failed the screening tests administered in all the schools in Manitowoc. Doctor Shahrokh was assisted by a hearing consultant, city nurses, a county nurse, and two public school speech therapists. The otomobile, new in the state, has been visiting several other cities as well. It will be on display at the State Medical Society annual meeting in Milwaukee May 14–16. (Photo courtesy MANITOWOC HERALD)

New Director for Madison VA Hospital

Dr. William R. Merchant, chief-of-staff of the Veterans Administration Hospital at Ann Arbor, Mich., recently was named director of the VA Hospital in Madison. He succeeds *Dr. A. M. Gottlieb* who has been reassigned as director of the VA Hospital at Palo Alto, Calif.

According to an announcement by Veterans Administrator William J. Driver, Doctor Merchant is especially well qualified for his new job because he teaches internal medicine at the University of Michigan and the Madison hospital is affiliated with the University of Wisconsin Medical School.

Dr. Salan Returns to Waupaca

Dr. Jerry R. Salan, Waupaca, recently returned to his practice of medicine after serving with the U. S. Army in Texas and California. He entered service in March 1966.

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PHYSICIAN NEWS *continued*

Dr. Leo Grieben Speaks

Dr. Leo Grieben, psychiatrist at Tri-County Mental Health Clinic, Baldwin; Dunn County Hospital, Menomonie; and St. Croix County Hospital, New Richmond, spoke on "Current Trends in Psychiatric Treatment" at the Feb. 22 meeting of the St. Croix County Association for Mental Health in Hudson.

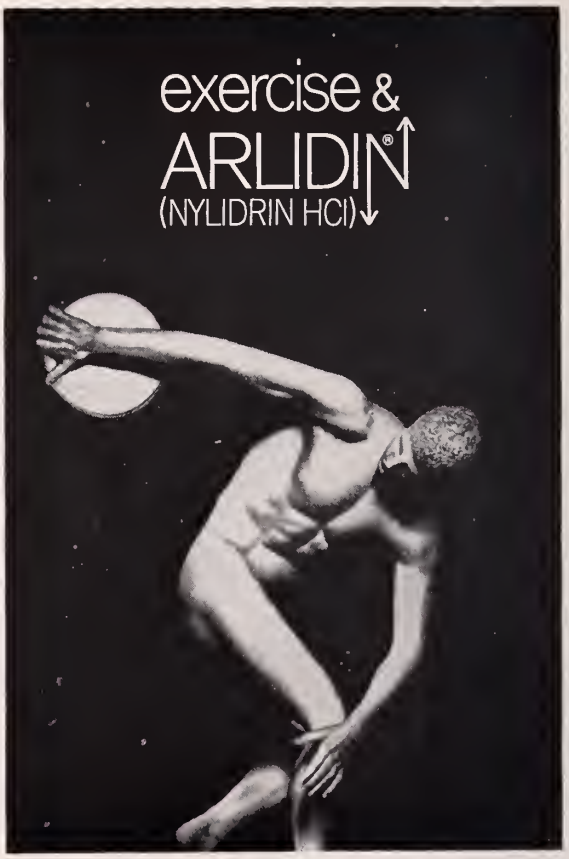
Mental Health Group Speaker

Dr. Darold A. Treffert, superintendent of Winnebago State Hospital, addressed members of the Dunn County Association for Mental Health on the subject, "Adolescence—a Healthy Disease." Doctor Treffert is chairman of the Division on Alcoholism and Addiction of the State Medical Society.

Dr. Pamukcu Opens Office

Dr. Afet Pamukcu, an internist, opened a new office March 1 in Kenosha.

Doctor Pamukcu, a native of Bulgaria, received her MD degree in 1951 from Istanbul University Medical School, Turkey. A rotating internship was taken at Newport, R.I., Hospital. Residency training in internal medicine was done at Illinois Masonic Hospital and Cook County Hospital, Chicago. She also furthered her studies at Boston City Hospital and Northwestern University.



BROWN

Society's Aid Asked in Development of Model Student Health Program

Plans for development of a Student Health Program at the University of Wisconsin–Green Bay were outlined by Dr. Fred Sargent at the Feb. 8 meeting of the Brown County Medical Society. Doctor Sargent, dean of the College of Environmental Sciences and acting dean of the College of Human Biology during planning stages, asked for the Society's assistance in planning health services for a projected 27,000 students and employes of the UW–GB. He noted that the present system of referring students to community clinics or hospitals will not be adequate within 15 or 20 years.

Doctor Sargent recommended the formation of a standing committee composed of medical society representatives from the major counties to be served by the university to help develop a master plan for health services which could also be used as a model for other universities.

Doctor Sargent has been conferring with *Dr. Peter Eichman,* dean of the University of Wisconsin Medical School in Madison, to develop a working relationship with the medical school since students taking pre-medical liberal arts education in Green Bay will be able to transfer to the Madison medical school. He emphasized, however, that there are no plans for medical education at the UW–GB in the form of a medical school.

In other business the president, *Dr. Leonard C. Miller* suggested having a hobby show prior to the December meeting in conjunction with the Woman's Auxiliary. It was noted that several physicians are interested in such hobbies as painting; woodworking; coin, gun, and figurine collecting; photography; gardening; ship models; airplane, sailing, and horse enthusiasts.

OUTAGAMIE

Society Opposes Excessive Weight Loss by High School Wrestlers

During the business session of the Outagamie County Medical Society Feb. 15, members went on record as being opposed to the practice of high school wrestling coaches encouraging their boys to lose excessive amounts of body weight in order to compete favorably in wrestling matches. Society members feel that these are not mature men but are growing boys with a definite need for adequate food intake and rapid loss of weight can be bad for their general health. This attitude is being made known to athletic directors and principals at area schools. The Society plans to sponsor a resolution concerning this matter for consideration by the State Medical Society's House of Delegates when it meets in May in Milwaukee.

The scientific portion of the meeting concerned the use of computers in clinical medicine. Dr. Warner Slack of the University of Wisconsin was the guest lecturer.

KENOSHA

Dr. George Rowe Discusses Heart Disease

Fifty members of the Kenosha County Medical Society heard heart specialist, *Dr. George G. Rowe,* discuss current diagnostic and surgical treatment of coronary heart disease at the March 7 meeting. Doctor Rowe is professor of medicine, University of Wisconsin Medical School, Madison.

ASHLAND–BAYFIELD–IRON

Marshfield Endocrinologist Speaker

Medical management of goiter was discussed by *Dr. Thomas F. Nikolai* at the Feb. 29 meeting of the Ashland–Bayfield–Iron County Medical Society. Doctor Nikolai is an endocrinologist with the Marshfield Clinic. The Woman's Auxiliary also met at this time.

TREMPEALEAU–JACKSON–BUFFALO

Dr. Sautter Speaks on Pulmonary Embolism

Dr. Richard D. Sautter of the Marshfield Clinic was guest speaker at the Mar. 26 meeting of the Tri-County Medical Society. His subject was pulmonary embolism.

GREEN LAKE–WAUSHARA

Wausau Ophthalmologist Speaker

Dr. Gordon L. Backer, Wausau ophthalmologist, addressed 18 members of the Green Lake–Waushara County Medical Society Mar. 12 at Wautoma. He spoke on retinal pathology in hypertensive and diabetic diseases and also presented slides.

During the business session the Society gave approval for a cardiac consultation clinic and a tuberculin survey to be conducted by the Wisconsin Division of Health.

WALWORTH

Depression Topic of Dr. Baltes

Management of depression in office practice was discussed by Dr. Bernard J. Baltes at the Feb. 15 meeting of the Walworth County Medical Society. Plans were also made for a measles immunization program throughout Walworth county.

Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETIES

Wisconsin Society of Plastic Surgeons

At the recent annual election of officers of the Wisconsin Society of Plastic Surgeons *Dr. Sidney K. Wynn,* Milwaukee, was elected president; *Dr. Gordon Davenport, Jr.,* Madison, vice-president; and *Dr. Wilbert Wiviott,* Milwaukee, secretary-treasurer.

Wisconsin Urological Society

The annual meeting of the Wisconsin Urological Society was held Apr. 19–20 at the Wisconsin Center in Madison. Visiting guest speaker was Dr. John Graynack, chief of Urology at Northwestern University Medical School.

Milwaukee Academy of Medicine

Dr. Arthur M. Vineberg talked on "Surgery of Coronary Artery Disease" at the 941st meeting of the Milwaukee Academy of Medicine Mar. 19 at the University Club. Doctor Vineberg is in the Department of Surgery, McGill University Faculty of Medicine.

Physicians whose names appear in italics are members of the State Medical Society.

Milwaukee Academy of Surgery

The Milwaukee Academy of Surgery met in Waukesha Mar. 25 at the Memorial Hospital. About 60 physicians attended the program which included the following speakers; *Drs. William D. Merkow, C. A. Desch,* and *Robert S. Monk* of the Waukesha hospital medical staff. Doctor Merkow discussed the history of surgery in Waukesha County; Doctor Desch spoke on the treatment of vertebral fractures, and Doctor Monk on inguinal hernia.

Specialty Groups Help Plan Program for State Medical Society Annual Meeting

Specialty groups in Allergy, Dermatology, Internal Medicine, Neurology, Obstetrics and Gynecology, Pediatrics, Radiology, Ophthalmology, Otolaryngology, Surgery, Othopedics, and Anesthesiology have helped plan the scientific program of the State Medical Society's Annual Meeting May 14–16 in Milwaukee. Program details for all the specialties will be found on pages 42–46 of this issue.

* * *

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Physicians Named to State Group

Two Wisconsin physicians have been appointed State Medical Society representatives to a state level "Advisory Committee on Professional Services" established under the auspices of the Wisconsin Council of Homes for the Aging, Inc.

They are: *Dr. David N. Goldstein* of Kenosha and *Dr. William T. Casper*, Milwaukee. *Dr. Albert J. Baumann* of Wauwatosa represents the Wisconsin Psychiatric Association.

The committee, representing 11 disciplines involved in serving the aging, will advise on professional services rendered by various disciplines in the field of the aging, evaluate their interdisciplinary professional services rendered in homes for the aging, assist in the establishment of guidelines for more effective accomplishment of interdisciplinary goals, communicate new developments and trends in respective fields of professional services as they relate to the aging, and foster communication between respective disciplines and between the disciplines and the council.

Other groups represented are the dentists, dietitians, nurses, physical therapists, occupational therapists, social workers, the State Department of Health and Social Services, and the Council of Homes for the Aging.

Better Medical Care for Upper Peninsula

Ways to improve the health care of "medically impoverished" areas of the Upper Peninsula were discussed in February at a meeting of the advisory committee of the Wisconsin Regional Medical Program. *Dr. John Hirschboeck*, coordinator of the WRMP, has been discussing this situation with representatives of similar programs in Minnesota and Michigan.

Several proposals have been made including one which involves developing a medical center at the Veterans Administration Hospital at Iron Mountain, Mich., and another which would establish a program of mobile diagnostic clinics that would bring medical services to the people.

Named to Birth Control Committee

Four physicians have been named to a committee to study controversial proposals to permit the sale of birth control devices to unmarried persons in Wisconsin. The Legislative Council approved the committee in February after the committee had been authorized by the 1967 legislature which failed to approve two bills that would have liberalized Wisconsin's birth control laws.

The physicians are: *Dr. Ben M. Peckham*, chairman of the Department of Gynecology and Obstetrics, University of Wisconsin Medical School, Madison; *Dr. John J. Brennan*, a Milwaukee obstetrician; *Dr. Joseph B. Durst*, president of the Wisconsin Society of Obstetricians and Gynecologists, La Crosse; and *Dr. Andrew M. Lucas* of Wisconsin Rapids.

The committee also includes three clergymen, and four other state citizens. Four legislators will also be named to the committee.

Legislation under consideration would take contraceptives off the list of items classified as obscene and make it possible for state welfare agencies to give information of birth control to unmarried women. A key issue in the study is whether Wisconsin will qualify for federal welfare aids if the present laws are not changed. The committee will report to the Council with recommendations prior to the 1969 legislative session.

Federal Health Services Seminar

Physicians, nurses, and hospital administrators in central Wisconsin joined the U.S. assistant secretary of health and medical affairs at a seminar in Marshfield March 16 to discuss the many government health programs available for improving community health service in the area.

The all-day program was presented by the Marshfield Clinic Foundation for Medical Research and Education with sessions at St. Joseph's Hospital.

The cabinet officer heading the program was Dr. Philip R. Lee who was accompanied to Marshfield by key Washington figures: James H. Cavanaugh, director of the office of comprehensive health planning of the U.S. Public Health Service; Dr. James English, acting director of health affairs for the Office of Economic Opportunity, and Karl Yordy, deputy director of the division of regional health programs for the National Institutes of Health.

Rounding out the speaker panel was *Dr. George H. Handy*, Madison, director of the State Bureau of Program Planning and Local Health Services.

The seminar chairman, *Dr. G. Stanley Custer* of the Marshfield Clinic, called the program "unequaled in Wisconsin, and as far as we know there will be no other such gathering in the nation this year where the regional physicians can talk about the federal medical programs with the Washington people heading those programs."

Cancer Research Grants

Cancer research grants totaling $52,998 were awarded to nine Milwaukee scientists by the Milwaukee Division of the American Cancer Society, it was announced recently by *Dr. L. J. Van Hecke*, division president.

Researchers obtaining the grants are Dr. Thomas W. Bednar, assistant professor, department of biol-

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Physicians whose names appear in italics are members of the State Medical Society.

ogy, Marquette University, $12,221; Dr. Donald Greiff, professor, department of pathology, Marquette School of Medicine, $11,232; *Dr. Richard I. H. Wang*, chief of pharmacology services, Marquette School of Medicine, $8,000; Dr. S. P. Masouredis, executive director, Milwaukee Blood Center and professor of medicine, Marquette School of Medicine, $7,400; *Dr. Roland A. Pattillo*, assistant professor, department of gynecology and obstetrics, Marquette School of Medicine, $6,700; Dr. Sidney E. Grossberg, professor and chairman, department of microbiology, Marquette School of Medicine, $4,000; and *Dr. Mortimer M. Bortin*, associate clinical professor of medicine, research laboratory, Mount Sinai Hospital, $3,445.

Doctor Van Hecke pointed out that the grants were approved by the cancer society's medical and scientific committee of which *Dr. James E. Conley* is chairman. Doctor Van Hecke added that these research grants were made possible through the community's support of the annual educational and fund-raising campaign of the American Cancer Society.

Pfizer Laboratories Medical Scholarships

Two Wisconsin residents are among the 94 students throughout the United States who were awarded $1,000 medical school scholarships during the 1967–68 academic year by the Pfizer Laboratories Division of Chas. Pfizer & Co., Inc.

The medical scholarship program provides each of the 94 medical schools in the United States with a $1,000 scholarship. These scholarships are administered solely by the dean of each medical school or by a committee established by him.

The two Wisconsin recipients were selected by the two medical school authorities on the basis of academic qualifications, financial need or both.

They are: Daniel David Kane, Milwaukee. Mr. Kane is a member of the class of 1969 at the University of Wisconsin Medical School at Madison. He is also a graduate of the University of Wisconsin in 1965.

Dorothy Ann Rollefson, Madison. Miss Rollefson is a member of the class of 1969 at Columbia College of Physicians and Surgeons, New York City. She is a 1965 graduate of Stanford University.

Waukesha Medical Assistants

Members of the Waukesha County Medical Assistants Society and their physician employers Feb. 14 heard about the ingredients of "good bosses" and good medical assistants. Mrs. Aleen Piepenburg, Madison, a past president of the Wisconsin State Medical Assistants Society, presented the after-dinner speech entitled, "The Boss."

Special guests at the event were *Dr. William D. James*, Oconomowoc, president-elect of the State Medical Society of Wisconsin, and Mrs. John Staszewski, Big Bend, president-elect of the WSMAS.

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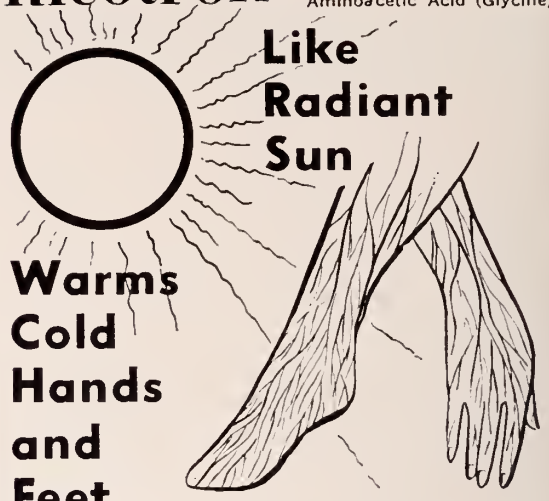

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REFERENCES:
1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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Wisconsin Medical Technologists

Members of the Wisconsin State Society of American Medical Technologists will meet May 18–19 in Wisconsin Dells at Kahler's Inn Towne Motel (formerly Uphoff's Motel). Co-chairmen are Devon Barrix, M.T. and Wilfred Wenberg, M.T.

The National Convention will be in July at Dallas, Tex. In September the Great Lakes District Meeting will be held in Chicago, Ill.

Chilton will be the host city for the State Meeting on November 2. Dale Brown, M.T., is chairman.

Manitowoc Medical Assistants

"Automation and modern electronic equipment are aiding in the pharmaceutical industry's never-ending search for new preventatives and cures," said Kelly C. Clark of Smith Kline & French Laboratories when he addressed members of the Manitowoc County Medical Assistants Society Feb. 20.

On the basis of medical progress in the first two-thirds of the century, the young American of the year 2000 will be a "medical wonder," Mr. Clark said. "He will use prescriptions that a billionaire today could not buy at any price." He cited several instances of medical progress and then said that "the use of modern technology and equipment in the research and development of new prescription products gives us reason for unlimited hope in the future of medical progress in America."

To Edit National Nursing Publication

Mrs. Signe S. Cooper, R.N., Madison, and *Dr. George G. Rowe*, Madison, have been named co-editors of "Cardio-Vascular Nursing," a bi-monthly publication of the American Heart Association. The Publication is distributed by affiliates of A.H.A. to nurses, hospitals, and clinics throughout the country.

"Cardio-Vascular Nursing" features in-depth articles contributed by leading authorities in the cardiovascular field and discusses the nurse's role in the treatment and management of cardiovascular disease. Mrs. Cooper and Doctor Rowe will serve as its editors for the next three years.

Mrs. Cooper, chairman of the Department of Nursing of the University of Wisconsin Extension, is a member of the Nursing Education committee of the American and Wisconsin Heart Associations. In 1967, she received the Linda Richards award of the National League of Nursing for her "unique and pioneering" contributions to the nursing profession. She is also a past president of the Wisconsin Nurses

Wausau Clinic Reports Successful Transmission of X-Ray Picture Via Telephone Facilities

THE FIRST KNOWN successful transmission of an x-ray picture over conventional long-distance telephone facilities was accomplished in an experiment conducted in Wausau in February.

Cooperating in the 240-mile test transmission from Wausau to Chicago were the Wausau Clinic, General Telephone Company of Wisconsin, and United Press International. The experiment was conducted under the supervision of Myron Muckerheide, a technician at the medical clinic.

A black-and-white photographic print of an x-ray of a female skull was placed on a UPI Telephoto machine in Wausau, and the transmission to the Chicago office of UPI was completed several minutes later.

In Chicago, a telephoto machine reproduced a negative of the transmitted photograph which was returned to *Dr. Jacob H. Martens*, radiologist at the Wausau Clinic, for examination.

Mr. Muckerheide noted that "the successful transmission of a high-quality x-ray picture over long-distance telephone facilities may open a new avenue for rapid interpretation of x-rays by specialists far removed from the patient and attending physician."

General Telephone & Electronics participated in the experiment as part of a continuing program to expand and improve communications services. However, the company emphasized that although the technical feasibility of x-ray transmission by telephone facilities has been established, extensive development work still will be required to assure the consistent high-quality needed in each transmitted photograph.

In a 1963 experiment, Mr. Muckerheide achieved the first known successful transmission of an electrocardiogram (EKG) over telephone facilities when he transmitted an EKG from Wausau to Hawaii. EKG transmission via telephone lines since then has become increasingly popular among doctors and clinical centers in obtaining rapid interpretation of EKGs when a cardiologist is not immediately available at the attending physician's location.

The Wausau Clinic receives EKGs via telephone transmission over two systems installed on a permanent basis, and uses a third portable system as the need arises.

Myron Muckerheide, technician at the Wausau Clinic who supervised the experiment, is shown with Jerome W. Sheehy, Northern Division sales manager of General Telephone of Wisconsin, who is placing a telephone call to the Chicago office of UPI immediately prior to the first known successful transmission of an x-ray picture over conventional long-distance telephone facilities.

Similar installations of EKG transmitting equipment are in operation in hundreds of other locations across the country.

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Association and served on the Association's Board of Directors from 1960 to 1963.

Doctor Rowe is a professor of Medicine at the University of Wisconsin Medical School and is actively engaged in cardiovascular research. He is presently working under a Senior Research Fellowship granted by the U.S. Department of Health, Education, and Welfare and holds a Grant-in-Aid from the Wisconsin Heart Association for research on the control mechanism of the coronary artery during exercise.

Doctor Rowe is a fellow in the American College of Physicians and a diplomate in the American Board of Internal Medicine. He served on the Board of Directors of the Wisconsin Heart Association from 1957 to 1967 and is a former research fellow of the American Heart Association.

The first issue of "Cardio-Vascular Nursing" edited by Mrs. Cooper and Doctor Rowe was published the end of February.

Urges Increased Teaching of Human Sexual Behavior to Medical Students

A leading educator on sex and the family urged increased teaching of human sexual behavior to medical students so that they may better deal with sex as part of the total health problems of their patients, in an address Mar. 12 in Milwaukee.

Clark E. Vincent, Ph.D., spoke at the second annual Marquette School of Medicine Student American Medical Association lecture. Doctor Vincent is director of Behavioral Sciences Center at Bowman Gray School of Medicine, Winston–Salem, N.C., is a past president of the National Council on Family Relations, and a founder of SIECUS, the Sex Information and Education Council of the United States. He is the author of a book to be published this spring, "Human Sexuality in Medical Education and Practice," which was previewed in his lecture in Milwaukee.

While in Milwaukee, he also spoke at a luncheon at the YWCA sponsored by the University of Wisconsin Extension Division, the YWCA, Planned Parenthood, Mental Health Association of Milwaukee County, and the Jewish Community Center; and at a dinner meeting of the Milwaukee Gynecological Society.

GUIDE: RE-TRAINING IN MEDICAL TECHNOLOGY

A new publication, "Curriculum Guides for Re-Training in Medical Technology," is now available for those who instruct technologists who have been inactive in the field, the U. S. Public Health Service's Bureau of Health Manpower (BHM) has announced.

Basically an outline of suggested content for technology retraining courses, the publication was produced under a BHM contract by the National

Committee for Careers in Medical Technology under the supervision of the National Council on Medical Technology Education.

"Curriculum Guides for Re-Training in Medical Technology," is a 312-page publication, covering 12 subjects: basic science; examination of urine, semen, and gastro-intestinal contents; hematology; coagulation; blood banking and immunohematology; microbiology; parasitology; immunology–serology; instrumentation; chemistry; radioisotopes; and laboratory administration and supervision. Each section includes references for suggested student reading, and most sections include suggested questions for evaluating student proficiency.

"Curriculum Guides for Re-Training in Medical Technology" may be obtained from the National Committee for Careers in Medical Technology, 1501 New Hampshire Avenue, N. W., Washington, D. C. 20036, at $2.75 a copy to cover production and mailing costs.

FILM: HYPERTENSION

A new film, "Hypertension: The Challenge of Diagnosis," has been produced by the American Heart Association assisted by a grant from E. R. Squibb & Sons, Inc. The film demonstrates and emphasizes the fact that the proper treatment of hypertension can be determined only when diagnostic measures have found the cause of hypertension and the damage it has done.

Visually, the film follows the case of a typical patient with no significant complaint, whose elevated blood pressure was first noted incidentally, and who had a family history of vascular disorder.

First, possible causative factors are considered. Listed are diseases most often implicated, together with significant signs and symptoms. What damage has been done to the patient is then sought, noting the organs most commonly affected. Significant signs of symptoms of the patient are described. Following are the steps of a thorough physical examination and the reasons for them for evidence to support clues already obtained or to suggest alternatives. Possible laboratory studies are described to substantiate a suspected cause of secondary hypertension.

The film concludes with a brief discussion of treatment, stressing the highly individualized patient management and that nearly every case represents a therapeutic trial which may take many months to complete.

The color, sound, 20-minute, 16 mm. film is available for professional medical audiences from local Heart Association chapters or from E. R. Squibb & Sons, Inc., 745 Fifth Avenue, New York City.

* * *

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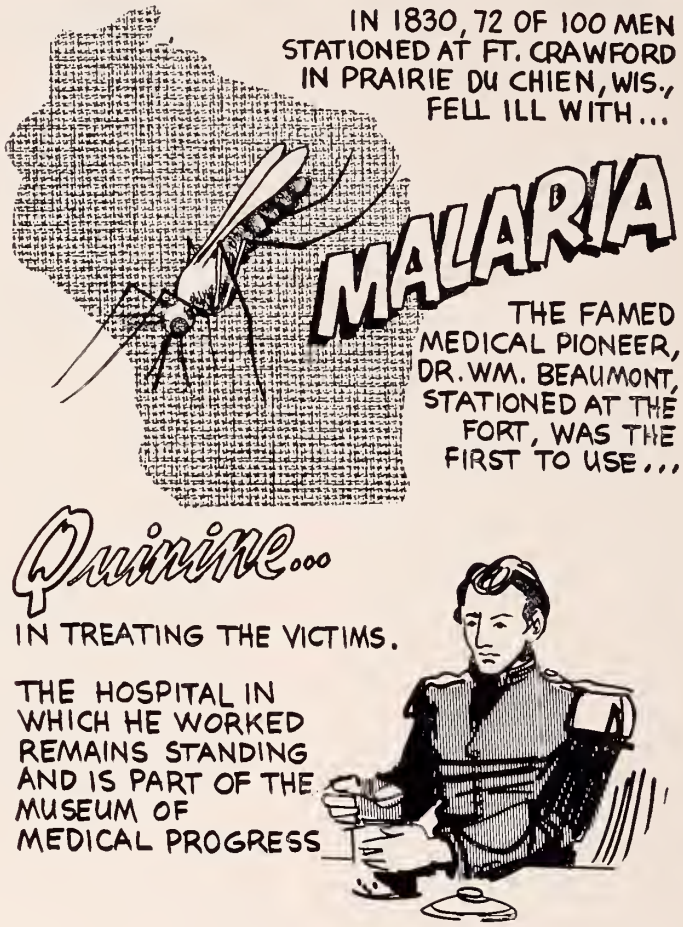

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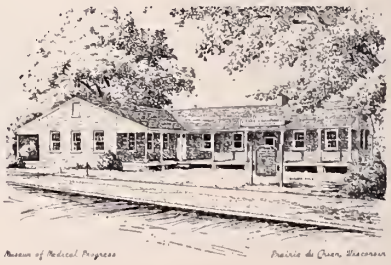

OBITUARIES

Dr. Lawrence W. Gregory, 70, a former Manitowoc physician, died Jan. 2, 1968, in Oakland, Calif.

Doctor Gregory graduated from the University of Wisconsin Medical School and did intern work at Southern Pacific Hospital, San Francisco, and residency work at Shriners Hospital in Philadelphia. He served in the United States Army Medical Corps in World War II and a certificate of merit was awarded to him in recognition of conspicuous meritorious and outstanding performance of military duty.

He was a former member of the Manitowoc County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, and two sons, John, a student in Germany, and David, who is on the staff of a Pennsylvania university.

Dr. A. W. Kozelka, 69, Two Rivers, died Jan. 9, 1968, in Two Rivers.

Doctor Kozelka received his Ph.D. in Zoology from the University of Pittsburgh in 1930 and his M.D. from the Rush Medical College, Chicago. He was a resident-surgeon from 1937 to 1939 at the Hospital of St. Anthony de Padua in Chicago before coming to Two Rivers. Doctor Kozelka wrote several papers on Integumental Grafting and Serological Studies of Tissue Antagonism. He was a former chief-of-staff of the governing board of Holy Family Hospital, Manitowoc, and a member of the medical staffs of Two Rivers Municipal, Manitowoc Memorial, and Holy Family hospitals. Doctor Kozelka was a veteran of World War I and belonged to the American Academy of General Practice.

He was a member of the Manitowoc County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Emily, and a son, Dr. John D., a Two Rivers dentist.

Dr. Charles T. Dunham, 52, former Racine physician, died Jan. 12, 1968, in St. Petersburg Beach, Fla.

Doctor Dunham graduated from the Marquette University School of Medicine in 1950 and interned at Passavant Memorial Hospital, Chicago, Ill.

Surviving are his widow, Katherine; four sons, Lon, Gary, Charles Jr., and John; and a daughter, Mrs. Robert Schwabe, Racine.

Dr. Arthur J. Kampmeier, 80, retired eye, ear, nose, and throat specialist, died Jan. 27, 1968, in Milwaukee.

Doctor Kampmeier graduated from the Marquette University School of Medicine in 1912 and took his internship at St. Mary's Hospital, Milwaukee.

Surviving are his widow, Agnes; and two daughters, Adeline Kunesh, Covina, Calif., and Lucille Frick.

Dr. Hamilton A. Bolstad, 83, DeSoto, died Jan. 29, 1968, in La Crosse.

Doctor Bolstad graduated from the University of Iowa Medical School in 1913 and served his internship at the University of Iowa Hospital. He was a member of the Vernon County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving is a son, James, St. Paul, Minn.

Dr. Erwin C. Van Valin, 65, Sussex, died Feb. 4, 1968.

Doctor Van Valin graduated from Marquette University School of Medicine in 1930 and served his internship at St. Mary's Hospital in Milwaukee. He had been on the staff of Waukesha Memorial Hospital for 37 years. Doctor Van Valin was a past president and delegate to the state convention of the Waukesha County Medical Society, and a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Alvina, and two children, Mrs. Theodorea Wiesneski, Menomonee Falls, and James, Brookfield.

Dr. Henry Blank, 69, Milwaukee, died Feb. 8, 1968, in Milwaukee.

Doctor Blank graduated from the Chicago Medical School in 1928 and interned at Saginaw General Hospital, Saginaw, Mich.

Surviving is his widow, Harriet.

Dr. Howard Clark Miller, 93, retired Whitewater physician, died Feb. 9, 1968, at Fairhaven.

Doctor Miller graduated from the Wisconsin College of Physicians and Surgeons, now the Marquette medical school, and lectured there for several years. He served overseas during World War I with the Medical Officers Reserve Corps and held the office of mayor of Whitewater for two terms.

Surviving are two sons, Dr. Russell H. Miller, Whitewater; and Dr. Clark A. Miller, Genoa City; and a daughter, Mrs. John H. Schneider, Winnetka, Ill.

Dr. Benjamin J. Malnekoff, 67, Milwaukee, died Feb. 12, 1968, in Milwaukee.

Doctor Malnekoff graduated from the University of Illinois College of Medicine in 1924 and interned at Cook County Hospital, Chicago. He served in the United States Army during World War I. He was a member of the faculty of Marquette University. Doctor Malnekoff completed postgraduate work in Vienna, Berlin, and Paris. While practicing in Milwaukee he was on the medical staffs of Milwaukee County, Mt. Sinai, and Milwaukee Children's hospitals. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. He also was a member of the American Academy of Pediat-

rics and was certified by the American Board of Pediatrics.

Surviving are his widow, Esther; and two children, Diane, San Francisco, and John, Los Angeles.

Dr. Michael Kasak, 83, Milwaukee, died Feb. 12, 1968, in Milwaukee.

Doctor Kasak was born in Latvia but educated above high school in the United States. He received his B.S. degree from the University of Wisconsin and graduated from Washington University School of Medicine, St. Louis, Mo., in 1917. After graduation he specialized in Neurology and Psychiatry at Washington University, Harvard, and the University of Berlin in Germany. He resided in the United States except for a three-year period when he returned to Latvia to help in the organization of the Neurological Department at the newly founded University of Latvia (Riga, Latvia), 1922 to 1925.

Dr. Michael Kasak

He was a past president of the Milwaukee Neuropsychiatric Society and until his retirement in 1956 was medical director of the Milwaukee County Hospital for Mental Diseases. He was an emeritus director and clinical professor of the Division of Psychiatry at Marquette University and special lecturer at Milwaukee–Downer and Mount Mary colleges. Doctor Kasak had published many scientific and popular articles and his biographical data are listed in *Who's Important in Medicine, Directory of Medical Specialists* and *Who's Who in America.*

Doctor Kasak was certified by the American Board of Psychiatry and Neurology and was a fellow of the American Psychiatric Association. He also was a member of the Central Neuropsychiatric Association, Illinois Psychiatric Society, and the American Academy of Neurology. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

In 1967, at the 126th annual meeting of the State Medical Society, he was honored as a "Fifty-Year Club" member of the Society.

Among his many awards, Doctor Kasak received the Award of Merit in 1955 for Postgraduate Medical Education from the Interstate Postgraduate Medical Association of North America. In 1956 upon his retirement, he was honored by the Milwaukee County Society for Mental Health. In 1961 Doctor and Mrs. Kasak received the International Institute of Milwaukee County, Inc. Distinguished Service Award.

Since Doctor Kasak's retirement in 1956 as medical director, he was a court-appointed expert witness in the field of psychiatry and was actively working until 1968. He had lectured at the Shorewood Opportunity School (1962–63–64) on "Great Literature as Seen By a Psychiatrist."

Surviving are his widow, Lauma, and a daughter, Mrs. James E. (Nenia) Detienne, of Milwaukee.

Dr. Lester O. Mastalir, 66, Milwaukee, died Feb. 15, 1968, in Madison.

Doctor Mastalir graduated from the Marquette University School of Medicine in 1931 and served his internship at St. Mary's Hospital in Milwaukee. He practiced in Burlington for 32 years. He did postgraduate study in surgery at the Jackson Clinic, Madison, in 1955. At the time of his death, he was staff physician at the Veterans Administration Hospital, Wood. Doctor Mastalir was an associate of the International College of Surgeons and a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association, and a former member of Racine County Medical Society.

Dr. L. O. Mastalir

Surviving are his widow, Irene; two sons, Lester II, Madison, and Thomas, Milwaukee; and two daughters, Laura Claire, Milwaukee and Mary Joan, Chicago.

Dr. Frank S. Rybak, 82, Madison, died Feb. 16, 1968, in Madison.

Doctor Rybak graduated from the Marquette University School of Medicine in 1916 and served his internship at the City of Detroit Receiving Hospital. He had been associated with Mendota State Hospital for 25 years before his retirement in 1965.

Surviving are his widow, Mary Ann; two sons, Frank Jr., Middletown, N. Y., and Robert A., Rockford, Ill.; and two daughters, Irene, Madison, and Mrs. Alice Nelsen, Bowie, Md.

Dr. Marie Kersten Dubinski, 82, retired Stevens Point physician, died Feb. 19, 1968, in Angola, Ind.

Doctor Dubinski graduated from Loyola University Medical School, Chicago, in 1913 and interned at Mary Thompson Hospital, Chicago. In 1917 and 1918 she took postgraduate work in eye, ear, nose and throat in Chicago and was school physician with the Chicago health department. In 1921 she opened a practice in Stevens Point and practiced there until her retirement in 1960.

Surviving are a son, James, Wauwatosa, and a daughter, Mrs. John Druham, Tinley Park, Ill.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF FEBRUARY 29, 1968

NEW MEMBERS

Abroms, Gene M., 427 Lorch St., Madison 53706
Agarwal, Avadh B., 3975 N. Cramer St., Milwaukee 53211
Bahr, Robert D., 8901 W. Lincoln Ave., West Allis 53227
Botticelli, James T., 8700 West Wisconsin Ave., Milwaukee 53226
Bruner, Allen M., P. O. Box 188, Oconomowoc 53066
Browell, John N., Jr., 630 S. Central Ave., Marshfield 54449
Cozine, Winston I., 6308 Eighth Ave., Kenosha 53140
Dominguez, Oscar, 630 S. Central Ave., Marshfield 54449
Feiges, Lewis M., 2500 West Lincoln Ave., Milwaukee 53212
Froeschle, R. P., P. O. Box 354, Waukesha 53186
Glazier, Edward H., 915 North Hartwell, Waukesha 53186
Gomilla, Severino G., 6833—45 Ave., Kenosha 53140
Holtey, Warren J., 630 South Central Ave., Marshfield 54449
Klein, Martin H., 69 East Brooklyn St., Chilton 53014
Laufenburg, Herbert F., 3880 N. Richards St., Milwaukee 53212
Lavine, Daniel M., 948 North 12 St., Milwaukee 53233
Logan, Richard, 925 Mound St., Madison 53715
Miller, Marvin D., 8901 West Lincoln Ave., West Allis, 53227
Nacheff, Regene, 1300 University Ave., Madison 53706
Nichol, Kathryn P., 2753 Marshall Parkway, Madison 53713
Pamukcu, Afet, 7707 Seventh Ave., Kenosha 53140
Wadina, Gerald W., 2360 South 60 St., West Allis 53219

REINSTATED

Darin, Joseph C., 8700 West Wisconsin Ave., Milwaukee 53226

CHANGES OF ADDRESS

Adlam, Robert T., 5242 North Dent Ave., Milwaukee 53217
Anderson, Richard B., Madison, to 300 Longwood Ave., Boston, Mass. 02115
Angus, D. C., 403 Shirley, Green Bay 54304
Arnesen, Richard B., 1651 Morris Park Rd., McFarland 53558
Banker, Robert J., 210 East Reed Ave., Manitowoc 54220
Barbo, Dorothy M., Milwaukee, to Missionary Orientation Center, Crickettown Rd., Stoney Point, N. Y. 10980
Bender, Boris I., 1915 West Hampton Ave., Milwaukee 53209
Benjamin, H. B., 945 North 12th St., Milwaukee 53233
Berg, James F., Milwaukee, to 1600 N. West Fifth Ave., Mineral Wells, Tex. 76067
Biller, Saul E., 1610 North Prospect, Milwaukee 53202
Blanchard, H. H., Milwaukee, to 11533 N. Parkview Dr., 57 West, Mequon 53092
Bogle, Warren C., Madison, to St. Luke's Hospital, 2900 West Oklahoma Ave., Milwaukee 53215
Botka-Wunder, G. M., 2134 North Lake Dr., Milwaukee 53202
Brittin, Geoffrey M., 5406 Harold Ave., Madison 53716
Brooks, Jerome E., APO San Francisco, 96291, Calif., to Racine Medical Clinic, 5625 Washington Ave., Racine 53402
Conroy, Conde F., 714 East Glendale Ave., Milwaukee 53211
Dessloch, E. M., P. O. Box 89, Prairie du Chien
Doege, Paul F., Marshfield, to 2854 W. Magee Rd., Tucson, Ariz. 85704
Dortzbach, Richard K., Madison, to Bldg. 9 E-1200 Court de Ville, Birmingham, Ala., 35209
Erickson, Milo R., 712 Redwood Dr., Green Bay 54304
Franklin, Richard L., 2500 West Lincoln Ave., Milwaukee 53215
Fick, Kenneth R., Milwaukee, to 15520 Apple Valley Court, Brookfield 53005
Gersch, George P., Grand Rapids, Mich., to 431 West Garland St., West Salem 54669
Goldstein, Paul H., Milwaukee, to 4848 N. Ardmore Ave., Whitefish Bay, 53217
Hardie, G. H., 111 East North Water St., Neenah 54956
Heckman, Margaret G., Milwaukee, to Veterans Administration Hospital, Department of Pathology, Wood 53193
Heise, H. A., Milwaukee, to 8990 Alkire, Arvada, Colo. 80002
Hussussian, Jacques, Wauwatosa, to 2266 N. Prospect Ave., Milwaukee 53202
Jaramillo, Carlos A., L. Box 514, Monroe 53566
Just, John F., Milwaukee, to 13015 Cardinal Crest Dr., Brookfield 53005
Kennedy, William F., 111 East North Water St., Neenah 54956
Kleiman, Martin M. W., 7600 West Hampton Ave., Milwaukee 53218
Kottke, Merlin A., Milwaukee, to 7683 Overlook Dr., Greendale 53129
Latorraca, Carol W., Wauwatosa, to 331 West Silver Spring Dr., Milwaukee 53217
Leighton, Fredrick A., Sheboygan Falls, to 1820 N. 7th St., Sheboygan 43081
Linke, Darrell L., P. O. Box 512, Beaver Dam 53916
Matus, Simon, Ogdenburg, N.Y., to Box 66, Liberty, N.Y. 12754
Meyer, Robert J., Spring Valley, to 103 First Ave., West, Menomonie 54751
Milson, Stuart E., USARV 93rd Evacuation Hosp., APO San Francisco, 96491 Calif.
Murray, J. F., 2015 Lincoln Rd., Monroe 53566
Myers, Sherman C., 15280 Cascade Dr., Elm Grove 53122
Nachazel, Delbert P., Jr., Waukesha, to 20 Biscayne Blvd., Woodbury, N. J. 08096
Odland, Paul K., 305 East Court St., Janesville 53545
Owen, Nicholas L., Brookfield, to 425 East Wisconsin Ave., Milwaukee 53202
Pattillo, Roland A., Baltimore, Md., to Marquette School of Medicine, 8700 West Wisconsin Ave., Milwaukee 53226
Peterman, Mynie G., Arlington, Va., to Box 360 Leesburg, Va. 22075
Pratt, Mary V., Monroe, to 1300 University Ave., Madison 53706
Pratt, George N., Jr., 140 Main St., Menasha 54952

SOCIETY RECORDS *continued*

Raasch, H. Marilyn, Milwaukee, to 405 South Los Robles Ave., Pasadena, Calif. 91102
Robert, Rob Roy, Beaver Dam, to Route 4, Box 193, Mosinee 54455
Schaeffer, Frederick, 1416 Commercial St., Neenah 54956
Schmidt, Clements S., Middleton, to 2727 Marshall Court, Madison 53705
Schulz, Irwin, Milwaukee, to 8740 Parkview Court, Wauwatosa 53226
Sinclair, Eugene P., Milwaukee, to 13185 Lee Court, Elm Grove 53122
Siverhus, W. James, Madison, to Munson Army Hospital, Ft. Leavenworth, Kan. 66027
Steinmetz, George P., Jr., 110 Ozark Trail, Madison 53705
Swint, Margery J., 202 Hillside Rd., Oak Ridge, Tenn. 37830
Thatcher, L. Gilbert, Madison, to Marquette School of Medicine, 1700 West Wisconsin Ave., Milwaukee 53233
Tonkens, Samuel W., Milwaukee, to Veterans Administration Center, Wood 53193
Vakili, Hossein, Medford, to The Rhodsdendron Apt. 303, 10006 Spring St., Seattle, Wash. 98104
Varberg, Waldo R., 111 East North Water St., Neenah 54956
Voet, Raymond K., San Francisco, Calif., to Armed Forces Radiobiology Research Institute, Bethesda, Md. 20014
Von Jarchow, Bruno L., 5300 West Knollwood Rd., Racine 53403
Wagelie, Reuben G., 2031 Riverside Dr., Beloit 53511
Weisfeld, Samuel G., 3531 West Burleigh St., Milwaukee 53210
Wilson, Stuart D., Milwaukee, to 402 East Prospect Ave., Lake Bluff, Ill. 60044
Windeck, James., Box 370, Chippewa Falls 54729
Wirthwein, Carlton, 7635 West Bluemound Rd., Milwaukee 53213
Zimmerman, Delano E., Winnebago, to 1416 South Commercial St., Neenah 54956
Zubatsky, David J., Orange, Calif., to 17621 East 17 St., Tustin, Calif. 92680

REMOVED FROM MEMBERSHIP

Blum, Jerome V., Milwaukee County, resigned
Burris, B. Cullen, Milwaukee County, transferred to Illinois
Diaz-Esquivel, Jose, Wood County, transferred to Texas
Hampel, Donald C., Milwaukee County
Macksood, John M., Milwaukee County, transferred to Michigan
Rieselbach, Richard E., Dane County, resigned
Schwindt, Walter D., Dane County, resigned
Stead, William W., Milwaukee County, resigned
Stenberg, Clayton C., Green County, transferred to New Hampshire
Stengel, Bruce F., Milwaukee County, resigned
Till, Eugene W., Milwaukee County, resigned
Winkler, Howard A., Columbia–Marquette–Adams County

DEATHS

Kronzer, Joseph J., Winnebago County, Sept. 1, 1967
Kruszewski, Joseph L., Milwaukee County, Nov. 22, 1967
Grigsby, Roll O., Ashland–Bayfield–Iron Counties, Nov. 27, 1967
Walsh, James D., non-member, Dec. 7, 1967
Faulds, Robert C., non-member, Dec. 11, 1967
Haberland, John E., Milwaukee County, Dec. 15, 1967
Bauer, William W., non-member, Dec. 22, 1967
Mauel, Nicholas M., Monroe County, Dec. 30, 1967
Pfeifer, Fred J., Waupaca County, Dec. 31, 1967
Gregory, Lawrence W., non-member, Jan. 2, 1968
Hudek, Daniel F., Chippewa County, Jan. 1, 1968
Lahmann, Albert H., non-member, Jan. 5, 1968
Schubert, Frank J., non-member, Jan. 5, 1968
Miller, Edward A., non-member, Jan. 7, 1968
Kozelka, Adolph W., Manitowoc County, Jan. 9, 1968
Dunham, Charles T., non-member, Jan. 12, 1968
Kampmeier, Arthur J., non-member, Jan. 27, 1968
Bolstad, Hamilton A., Vernon County, Jan. 29, 1968
Van Valin, Erwin C., Waukesha County, Feb. 4, 1968
Blank, Henry, non-member, Feb. 8, 1968
Miller, Howard Clark, non-member, Feb. 9, 1968
Malnekoff, Benjamin J., Milwaukee County, Feb. 12, 1968
Kasak, Michael, Milwaukee County, Feb. 12, 1968
Mastalir, Lester O., Milwaukee County, Feb. 15, 1968
Rybak, Frank S., non-member, Feb. 16, 1968
Dubinski, Marie K., non-member, Feb. 19, 1968
Gorenstein, L. M., La Crosse County, Feb. 25, 1968

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BOOKS RECEIVED

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

NATIONAL INSTITUTE OF MENTAL HEALTH SUPPORT PROGRAMS

U.S. Department of Health, Education and Welfare. Public Health Service. National Institute of Mental Health, 5454 Wisconsin Avenue, Chevy Chase, Md. 20203. 54 pages.

PALLIATIVE CARE OF THE CANCER PATIENT

By 33 authors, edited by Robert C. Hickey, MD, Professor and Chairman, Dept. of Surgery, University of Wisconsin Medical School, Madison. Published by Little, Brown and Company, 34 Beacon St., Boston, Mass. 02106. 621 pages. Price: $23.50.

ATLAS OF STRABISMUS

By Gunter K. von Noorden, MD, Associate Professor of Ophthalmology and A. Edward Maumenee, MD, Professor of Ophthalmology. Published by C. V. Mosby Company, Saint Louis, 1967. 188 pages. Price: $17.50.

BURNS, SHOCK, AND PLASMA VOLUME REGULATION

By Carl A. Moyer, MD, Director of Research, Michigan Technological University and Harvey R. Butcher, Jr., MD, Professor of Surgery, Washington University School of Medicine. Published by C. V. Mosby Company, Saint Louis, 1967. 428 pages. Price: $18.50.

ANNUAL REPORT, The Surgeon General United States Army

Compiled by The Historical Unit, U.S. Army Medical Service. Published by Office of the Surgeon General, Department of the Army, Washington, D.C. 139 pages.

CARDIOVASCULAR PHYSIOLOGY

By Robert M. Berne, MD, professor, department of Physiology, University of Virginia School of Medicine and Matthew N. Levy, MD, chief of Investigative medicine, Mt. Sinai Hospital of Cleveland. Published by C. V. Mosby Co., St. Louis. 1967. 254 pages. Price: $10.75.

ATLAS OF DIAGNOSTIC TECHNIQUES AND TREATMENT OF RETINAL DETACHMENT

By William H. Havener, BA, MD, MS (ophth.), professor, dept. of Ophthalmology, Ohio State University, and Sallie Gloeckner, Medical Artist. Published by C. V. Mosby Co., St. Louis, Mo., 200 pages. Price: $18.00.

PUBLIC HEALTH REPORTS

U.S. Department of Health, Education, and Welfare. December 1967, Vol. 82, No. 12, including Annual Index. Price: 55¢.

PATIENTS, DOCTORS AND FAMILIES

By Faye C. Lewis, MD. Published by Doubleday and Company, Inc., Garden City, New York, 1968. 240 pages. Price: $4.95.

RELIGION AND MEDICINE, Essays on Meaning, Values and Health

Edited by David Belgum, published by Iowa State University Press, Ames, Iowa, 1967. 345 pages. Price: $5.95.

HANDBOOK OF FRACTURES

By Edgar Lee Ralston, published by C. V. Mosby Company, 1967. 299 pages. Price: $10.75.

FAMILY HOSPITAL AND SURGICAL INSURANCE COVERAGE: U.S. July 1962-June 1963

U.S. Department of Health, Education, and Welfare. November 1967, Series 10, No. 42. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 43 pages. Price: 30¢.

HOMICIDE IN THE UNITED STATES—1950–1964

U.S. Department of Health, Education, and Welfare. October 1967, Series 20, No. 6. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 33 pages. Price: 30¢.

PLAN, OPERATION, AND RESPONSE RESULTS of a Program of Children's Examinations

U.S. Department of Health, Education, and Welfare. October 1967, Series 1, No. 5. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 56 pages. Price: 40¢.

TOTAL LOSS OF TEETH IN ADULTS: U.S. 1960–1962

U.S. Department of Health, Education, and Welfare. October 1967, Series 11, No. 27. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 23 pages. Price: 25¢.

INFANT AND PERINATAL MORTALITY IN DENMARK

U.S. Department of Health, Education, and Welfare. November 1967, Series 3, No. 9. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 67 pages. Price: 45¢.

MULTIPLE BIRTHS: United States—1964

U.S. Department of Health, Education, and Welfare. October 1967, Series 21, No. 14. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 49 pages. Price: 35¢.

MODERN TREATMENT

Vol. 4, No. 6. Treatment of Obesity, guest editor, Charles A. Hollenberg, MD; and Treatment of Burns, guest editor, Charles L. Fox, Jr., MD. Cumulative Index 1965–1967. Hoeber Medical Division, Harper and Row, Publishers, New York. Published bimonthly. 1,200 pages annually. Subscription: $16.00 per year.

1968 DRUGS OF CHOICE 1969

By Walter Modell, Editor. Published by the C. V. Mosby Company, Saint Louis, Mo., 1967. 907 pages. Price: $17.95.

PROGRESS AGAINST CANCER 1967

A report by the National Advisory Cancer Council. U.S. Dept. of Health, Education, and Welfare Public Health Service, National Institutes of Health, Bethesda, Maryland 20014. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 65 pages. Price: 65¢.

BLACK MARKET MEDICINE

By Margaret Kreig. Bantam Books, 271 Madison Ave., New York, N.Y. 10016. 320 pages. Price: 95¢.

PHYSICIANS EXCHANGE

Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

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WANTED: Young General Practitioner, Internist, Pediatrician, and EENT man, to associate with 10-man group. New clinic building on 12 acres next to 100-bed hospital located northwest Waukesha County. Salary with partnership opportunity after first year. Contact Dept. 276 in care of the Journal. 10tfn

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WANTED ASSOCIATE general practice or general surgeon willing to do some general work. To associate with 2 general practitioners. Location in growing city of 8000. Good hospital connections. Good schools. Salary to start with early partnership. Contact Dr. P. B. Blanchard or Dr. John Kippenhan, Cedarburg, Wis. 53012. 4-9

WANTED: Physician to succeed retired Physician of City Health Dept., Racine, Wis. Located between Chicago and Milwaukee. Does not require M.P.H. Salary range $19,176-$20,448. Contact: Personnel Director, City Hall, Racine, Wis. 2-5

PEDIATRICIAN to join established department of pediatrics in 17-man midwestern group. Excellent opportunity in a growing dynamic clinic with early partnership. Town of 33,000 with two hospitals and excellent schools. Clinic staff enjoys regular vacations and time off for study. Contact Dept. 286 in care of the Journal. 2-4

INDUSTRIAL PHYSICIAN—Large heavy manufacturing company employing approximately 5,000. Progressive Medical Department staffed by 2 Physicians, 1 Dentist, 5 Nurses, and 6 Technicians. No private practice involvement. We're located one hour north of Milwaukee near the shore of Lake Michigan. Salary commensurate with experience. An equal opportunity employer. Write Personnel Director, Kohler Co., Kohler, Wis. p1-5

WANTED: GENERAL PRACTITIONER or General Surgeon willing to do general work as associate with 45-year-old General Practitioner in north central Wisconsin, town of 10,000. Full hospital privilege is available. Contact Dept. 231 in care of the Journal. m9tfn

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WANTED: Well-trained General Practitioner or Internist to associate with physician in town of 5,000 in east central Wisconsin. Excellent clinic and hospital facilities. Attractive salary with possibility of eventual partnership. Contact Dept. 127 in care of the Journal. m4tfn

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CONTENTS

Vol. 67, No. 5 MAY 1968

SCIENTIFIC ARTICLES

Pemphigus, Pemphigoid, or Dermatitis Herpetiformis?, by Harold O. Perry, M.D., Rochester, Minn. ---- 245

Medical History Feature: Cyclopropane—The Early Days at Wisconsin, by Howard P. Gutgesell, Jr., Madison ---- 251

Hemophilus Influenzae Meningitis; report of a case in an adult due to a nontypable organism, by Laurence G. Crocker, M.D., Madison ---- 254

Medical History Feature: William Osler's Education—Part II, by John H. Greist, M.D., Madison ---- 256

Therapeutic Dilemmas: Desquamative Interstitial Pneumonia (No. 7 of a Series), by Harry Beckman, M.D., Milwaukee ---- 260

Comments on Treatment: Current Treatment of Hypthyroidism, by Norman H. Engbring, M.D., Milwaukee ---- 265

SPECIAL FEATURES

Lipoid Pneumonia (abstract) ---- 259

Medical Memo: Museum of Medical Progress and Stovall Hall of Health ---- 268

The New President: William D. James, M.D. ---- 269

High Quality Drugs at Reduced Cost for Hospital Patients, by James Guenther, R.Ph., Sister M. Pio, Chief R.Ph. and Francis N. Lohrenz, M.D., Marshfield ---- 274

Task Force on Medical Education: Summary of Findings and Recommendations ---- 276

Minutes of Council Meeting: May 9–10, 1968, Madison ---- 281

EDITORIAL

Perplexing Doctrine ---- 271

REGULAR FEATURES

Publication Information ---- 4

Medical Meetings ---- 19

Letters ---- 273

The Medical Student Forum ---- 279

Section on Ophthalmology ---- 280

Wisconsin Physicians Service ---- 286

State Medical Society ---- 27

Physician News ---- 31

County Societies ---- 37

Specialty Societies ---- 40

Paramedical/Ancillary ---- 51

Obituaries ---- 59

Physicians Exchange ---- 62

Index to Advertisers ---- 64

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Journal
Established 1903

Annual Subscription ---- $10.00
Single Copy ---- 1.50
Previous Years' ---- 3.00
January Blue Book ---- 5.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago, Illinois 60610; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin 54481.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.

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Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances, manuscripts are published about six months following acceptance, and in the order in which they are received.

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RESPONSIBILITY. Publication of the WISCONSIN MEDICAL JOURNAL is under the direction of the Council of the State Medical Society of Wisconsin, with coordination through the Commission on Scientific Medicine. The Medical Editor and Editorial Board are responsible for the Scientific Content. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production, business operation, and all other contents of the JOURNAL, as well as final responsibility of the entire publication.

Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 WISCONSIN

May 29: Spring postgraduate meeting, Jackson Clinic and Foundation, Park Motor Inn, Madison.

June 7–9: Mid-year spring meeting, Wisconsin Society of Pathologists, Eagle Waters Resort, Eagle River.

June 7–9: Thirteenth annual meeting, Wisconsin State Medical Assistants Society, Milwaukee.

Aug. 22–24: Wisconsin "Cancer Chemotherapy 1968" conference course for physicians, Division of Clinical Oncology, University of Wisconsin Hospitals, Madison.

Sept. 12–14: Fall meeting, Wisconsin Society of Internal Medicine, Oshkosh, at The Pioneer.

Sept. 14–15 (tentative): Fall meeting, Wisconsin Otolaryngological Society.

Sept. 14–15: Fall meeting, Wisconsin Society of Anesthesiologists, Lake Geneva, at the Playboy Club.

Sept. 20–22: Fall meeting, Wisconsin Radiological Society, Lake Geneva, at the Playboy Club.

Sept. 21: Fall meeting, Wisconsin Surgical Society, St. Mary's Hospital, Madison.

Sept. 25: 1968 Wisconsin Heart Association–Adolf Gundersen Medical Foundation Symposium on Hypertension, Wisconsin State University at La Crosse.

Sept. 25–26: Annual meeting, Wisconsin Academy of General Practice, Pfister Hotel, Milwaukee.

Oct. 1–4: Sixth annual Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Oct. 5: 14th Annual Fall Cancer Conference (The Cancer Scrimmage), University of Wisconsin Medical Center, Madison.

Oct. 8–11: Meeting of the Wisconsin Nurses Association, Sheraton–Schroeder Hotel, Milwaukee.

Oct. 9–10: Meeting of Wisconsin Division, American Cancer Society, Oshkosh.

Nov. 16: Fall annual meeting of Wisconsin Society of Pathologists, Marquette School of Medicine, Milwaukee.

1968 NEIGHBORING STATES

June 10–14: "Internal Medicine," American College of Physicians, University of Iowa School of Medicine, Iowa City, Ia.

June 16–21: Midwest Institute of Alcohol Studies, Northwestern University, Evanston, Ill.

Sept. 26–29: "The Metabolic Basis of Heart Disease," American College of Physicians, Wayne State University School of Medicine, Detroit, Mich.

Oct. 12–18: Annual Otolaryngologic Assembly of 1968, Illinois Eye and Ear Infirmary at the Medical Center, Chicago, Ill.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

1968 OTHERS

June 11–14: 1968 Catholic Hospital Association Convention, Philadelphia Civic Center, Pa.

June 17–20: Postgraduate course: Obstetrics and Gynecology, University of Colorado School of Medicine, Stanley Hotel, Estes Park, Colo.

June 19: Joint Session of the American College of Cardiology with the Section of Internal Medicine of the American Medical Association and the American Heart Association, AMA Annual Meeting, San Francisco, Calif.

June 26–28: Summer clinics, Children's Hospital of Denver, Vail, Colo.

June 30–July 12: Physicians Institute on Medical Aspects of Alcoholism, Rutgers—The State University, New Brunswick, N.J.

June 30–July 6: Third International Seminar and Exhibition on World Problems in Rehabilitation of the Disabled, Conference Centre, Hotel Metropole, Brighton, England.

July 8–11: Postgraduate course: Ophthalmology, University of Colorado School of Medicine, Stanley Hotel, Estes Park, Colo.

July 15–18: Third annual conference on The Changing Role of the Medical Record Librarian, University of Colorado School of Medicine, The Stanley Hotel, Estes Park, Colo.

Aug. 1–3: Postgraduate course in Dermatology, University of Colorado School of Medicine, Aspen, Colo.

Aug. 5–8: Postgraduate course in Pediatrics, University of Colorado School of Medicine, Aspen, Colo.

Sept. 7–11: Second International Congress of the Transplantation Society, Americana Hotel, New York City.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo

Sept. 28–Oct. 3: Western Hemisphere Congress, International College of Surgeons, Honolulu, Hawaii.

Oct. 6–11: XVI Biennial International Congress, International College of Surgeons, Tokyo, Japan.

Oct. 9–11: 15th Western Cardiac Conference, University of Colorado Medical Center, Denver, and Colorado Heart Association.

Oct. 15–18: 51st Annual Meeting, American Dietetic Association, San Francisco, Calif.

Oct. 16–26: Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, International College of Surgeons.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

Oct. 26–Nov. 11: Around-the-World Postgraduate Clinics, International College of Surgeons, India, Egypt, Holy Land, Israel, and Greece.

Nov. 11–14: Interstate Postgraduate Medical Association Assembly, Pittsburgh, Pa.

Nov. 13–16: Forty-seventh annual convention, National Easter Seal Society for Crippled Children and Adults, Sheraton-Boston Hotel, Boston, Mass.

Nov. 19–20: 22nd Annual Meeting, American Heart Association Council on Arteriosclerosis, Bal Harbour, Fla.

Nov. 20–22: Sixtieth annual conference, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Nov. 21–24: 41st Scientific Sessions, American Heart Association, Bal Harbour, Fla.

Nov. 22–23: Psychedelic Drugs meeting, The Hahnemann Medical College and Hospital of Philadelphia, Pa.

Nov. 25–26: Annual Assembly Meeting, American Heart Association, Bal Harbour, Fla.

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MEDICAL MEETINGS *continued*

1969 OTHERS

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

1968 AMA

June 16–20: 117th Annual Convention, San Francisco, Calif.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

National Cancer Conference in Madison

The University of Wisconsin Medical School division of clinical oncology will hold its eighth annual National Cancer Conference Aug. 22–24 at the Park Motor Inn, Madison.

The conference—"Cancer Chemotherapy '68"—is open to all United States physicians interested in cancer chemotherapy.

The guest faculty will include: Emil Frei, III, M.D., associate director (clinical research), M.D. Anderson Hospital and Tumor Institute; Jesse Steinfeld, M.D., associate director, program, National Cancer Institute; Howard E. Skipper, Ph.D., vice-president and director of the Kettering–Meyer Laboratories; Charles Heidelberger, Ph.D., U.W. professor of oncology; Ovid Meyer, M.D., U. W. professor of medicine, and Kenneth M. Endicott, M.D., director of National Cancer Institute.

The rest of the faculty is from the division of clinical oncology, including Fred J. Ansfield, M.D., program director.

The division of clinical oncology is internationally known for its work on experimental cancer drugs. The University Hospitals serve as headquarters for National studies of new drugs used against varieties of cancer under a grant from the National Cancer Institute. Dr. Anthony R. Curreri, professor and chairman of surgery, is the director of the drug program.

Electronics and Instrumentation Techniques

The Polytechnic Institute of Brooklyn, N. Y., is planning to offer a three-week intensive course in basic electronics and instrumentation techniques during late July and early August this summer. This will be a laboratory course designed for engineers, physical and biological scientists, and science educators who must use instruments in their work. Further details: PIB, 333 Jay Street, Brooklyn, N. Y. 11201. Kenneth R. Jolls.

Congress of Cardiology, Israel

The Fourth Asian–Pacific Congress of Cardiology will be held Sept. 1–7 in Tel Aviv and Jerusalem, Israel. The Congress will be devoted to specific problems in the Asian–Pacific area and to subject matter of global interest.

The American Heart Association is coordinating arrangements for United States participation, including the screening of abstracts for presentations by U. S. authors. Further details: Department of Councils and International Program, AHA, 44 East 23rd St., New York, N. Y. 10010.

Immediately following the Asian–Pacific Congress is the Fifth European Congress of Cardiology, scheduled for Sept. 8–14 in Athens, Greece. Further details: Same as above.

Occupational Health, Nurses in Industry

A full-time, five-day course in occupational health for registered professional nurses in industry will be offered beginning Monday, Nov. 11, by the department of environmental medicine of New York University Medical Center, in cooperation with the American Association of Industrial Nurses. The course is limited to nurses with experience of five years or less in occupational health.

Tuition will be $150. Course #484. Applications to: Office of the Recorder, New York University Post-Graduate Medical School, 550 First Avenue, New York, N. Y. 10016.

Clinical and Life Insurance Medicine

The close link between clinical and life insurance medicine will be explored by a congress on medicine and insurance to be held in San Francisco June 15. The meeting, cosponsored by the Association of Life Insurance Medical Directors of America and the American Medical Association, is the first such meeting of the two organizations. Further details: Institute of Life Insurance, 277 Park Avenue, New York, N. Y. 10017; tel. 922–3015.

Interstate Postgraduate Medical Assembly

The 53rd annual scientific assembly of the Interstate Postgraduate Medical Association will be Nov. 11–14 at the Pittsburgh Hilton Hotel in Pittsburgh, Pa. This teaching program is of special interest to the family physician. Social activities include a boat ride, style show, and an art-flower tour.

Speakers include Drs. Edward A. Banner, Rochester, Minn.; Boris Senior, Boston, Mass.; Robert M. Zollinger, Columbus, Ohio; Kaye H. Kilburn, Durham, N. C.; Edward H. Rynearson, Rochester, Minn.; H. Hoyle Campbell, Toronto, Ontario; James Leonard, Donald Leon, and James Shaver, Pittsburgh; Charles R. Shuman, Philadelphia; T. S. Danowski, Pittsburgh;

Sean Mullan, Chicago; Dwight C. Hanna, III. Pittsburgh; Leon I. Goldberg, Atlanta, Ga.; E. S. Gordon, Madison, Wis.; Leonard L. Lovshin, Cleveland, Ohio; Herbert D. Adams, Boston, Mass.; Vinton E. Siler, Cincinnati, Ohio; Edward T. Bowe, New York City; Alton Ochsner, New Orleans, La.; and William H. Masters, St. Louis, Mo.

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The program is acceptable for 23 elective hours by the American Academy of General Practice. Further details: Interstate Postgraduate Medical Association, 333 North Randall Avenue, Madison, Wis. 53706.

Western Cardiac Conference, Colorado

The 15th Western Cardiac Conference, sponsored by the Colorado Heart Association, will be held Oct. 9–11 at the University of Colorado Medical Center, Denver.

Subjects include: Altitude and Sports Medicine, Congenital Heart Disease, Current Problems in Coronary Care, Auscultation and Arrhythmias, and Cardiac Surgery.

Guest speakers are: Dr. S. Gilbert Blount, Jr., University of Colorado Medical Center; E. R. Buskirk, PhD, Pennsylvania State University; Dr. Eliot Corday, UCLA; Dr. Alexander Nadas, Harvard University School of Medicine; Dr. Abe Ravin, Denver; Dr. Ray Shepard, Toronto, Canada; and Dr. Albert Starr, University of Oregon.

Further details: Colorado Heart Association, 1375 Delaware St., Denver, Colo. 80204.

The June AMA Convention—"Keeping Up"

Demands placed upon the American health care system have made the health services industry the nation's fastest growing employment field, American Medical Association president Dr. Milford O. Rouse, pointed out in a year-end report.

"Fifteen years ago it was the fifth largest employer, now it is third," said Doctor Rouse. "If present trends continue, it will become the nation's No. 1 employer by the early 1970s."

Few physicians need instruction in the facts concerning increasing demand.

In addition to the growing claims upon him by patients, medical society, hospital, civic affairs, and family, the physician faces his responsibility to himself to "keep up" with medical developments.

The year-around task of "keeping up" is manifested by the stack of medical journals, which is regularly attacked but often seems to be self-regenerating.

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The 117th Annual Convention of the AMA will be held June 16–20 this year in San Francisco. The Civic Auditorium, War Memorial Opera House, and several nearby hotels will house the scientific program; the House of Delegates will meet in the Fairmont Hotel.

Approximately 600 scientific papers are to be presented, and more than 250 scientific exhibits will be on display as well as many industrial exhibits.

Among special presentations planned are four General Scientific Meetings on automobile accidents, health care planning, management of infectious diseases, and treatment of advance malignant disease.

Four General Scientific Sessions will be presented and the 23 Scientific Sections will offer programs individually, many holding joint meetings on subjects of common interest.

A full schedule of medical motion pictures is planned, as is a program of live color telecasting from a San Francisco-area medical center.

Gundersen Symposium on Hypertension

The 1968 annual symposium of the Adolf Gundersen Medical Foundation and Wisconsin Heart Association will be held Wednesday, Sept. 25, at the Wisconsin State University in La Crosse. There will be morning and afternoon sessions (9:30 am to 12:30 pm and 2:30 pm to 4:00 pm) with individual papers being given in the morning session and a panel discussion in the afternoon.

The subject of this year's symposium is Hypertension. Medical speakers and panel members of this symposium are:

COLIN DOLLERY, MD—Lecturer in Clinical Therapeutics, Postgraduate Medical School and Consultant Physician to Hammersmith Hospital in London, England.

LEON I. GOLDBERG, MD—Professor of Medicine and Pharmacology, Emory University School of Medicine, Atlanta, Ga.

JOSEPH J. KAUFMAN, MD—Professor of Surgery, Urology, University of California, Los Angeles.

THEODORE L. GOODFRIEND, MD—Assistant Professor of Medicine and Pharmacology, University of Wisconsin, Madison, Wis.

DAVID R. ROVNER, MD—Associate Professor in Internal Medicine, Division of Endocrinology and Metabolism, University of Michigan, Ann Arbor.

All physicians are invited to attend. Registration fee is $5 and advance registration is requested. For further information: A. Erik Gundersen, MD, Program Chairman, Adolf Gundersen Medical Foundation, La Crosse, Wis.

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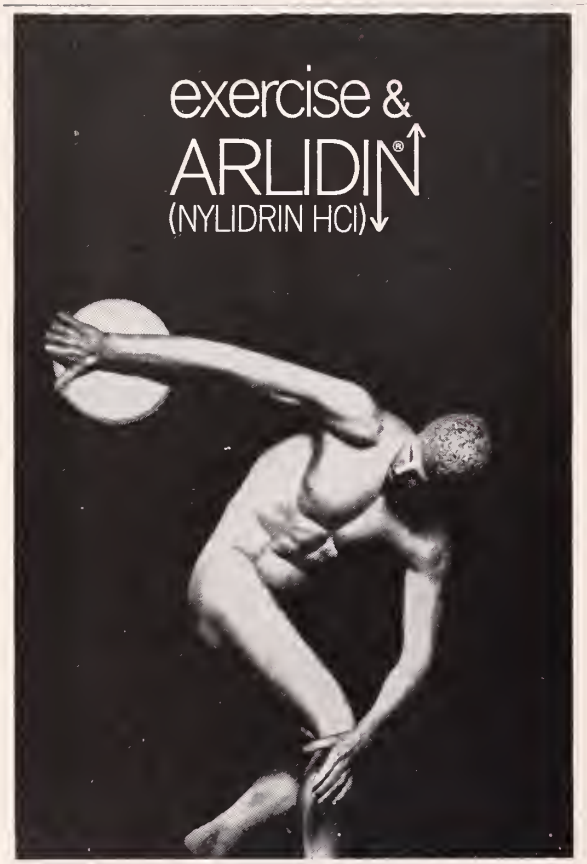

SOCIETY FOR CRYOSURGERY

The Society for Cryosurgery was recently formed to meet the needs of physicians and surgeons applying cryogenic procedures in their practice. The Society will keep all members informed of new advances and developments in this rapidly growing field by holding annual meetings and by publishing THE JOURNAL OF CRYOSURGERY.

Membership is also open to biologists, biophysicists, biochemists and biomedical engineers involved in various aspects of cryosurgery, as well as physicians and surgeons utilizing low-temperature therapy; all of whom are invited to participate by attending meetings and submitting manuscripts.

Members wishing to present papers at the meeting to be held Jan. 12–17, 1969, in Miami Beach, Fla., should submit title, abstract, and length of report as soon as possible.

Manuscripts, editorials and proceedings of meetings pertinent to cryotherapy and cryogeny are now being solicited for early publication in THE JOURNAL OF CRYOSURGERY. Papers should be typed in double space with margins on standard white bond paper.

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Chicago, Illinois 60602

Wisconsin Medicine, Agriculture Lend Helping Hand in Nicaragua

Representatives of Wisconsin medicine and agriculture visited Nicaragua in April to help solve problems of public health and nutrition there. They are *Dr. Henry A. Peters*, Madison, and Hugh Highsmith, Ft. Atkinson, both members of Governor Warren P. Knowles' committee on Partners for Progress.

Under the Alliance for Progress, founded in 1965, Wisconsin and Nicaragua are "sister states."

Doctor Peters represented the State Medical Society in an offer to assist the physicians of Nicaragua, who have recently started organizing their own medical society for the advancement of the profession and public health in that country.

Doctor Peters took with him a letter from Governor Knowles expressing the hope that a sharing of the Wisconsin medical society's 126 years of public health leadership "will be of great value to the citizens of Nicaragua."

The Wisconsin medical society is providing organizational advice on how to set up programs for postgraduate education, staff hospitals, establish guidelines for public health programs, organize the delivery of medical services, and develop health education projects.

Mr. Highsmith, publisher of FARMER'S DIGEST and president of a Ft. Atkinson manufacturing firm, is particularly interested in agricultural and commercial development in Nicaragua. An agriculture expert, he discussed rural development programs with farm leaders in Nicaragua.

WISCONSIN MEDICINE and agriculture in April reaffirmed their bond of friendship with Nicaragua under the Alliance for Progress which links the two as sister states. Governor Warren P. Knowles conferred with Dr. Henry A. Peters, Madison (center), and Hugh Highsmith, Ft. Atkinson, before they departed for the Central American state.

Since Doctor Peters first visited Nicaragua in 1965, Wisconsin has sent about $40,000 worth of used hospital equipment for use in Nicaraguan hospitals. Substantial contributions have been made by St. Luke's Hospital, Racine; Mt. Sinai Hospital and St. Joseph's Hospital, Milwaukee; Door County Memorial Hospital, Sturgeon Bay; Ohio Medical Products, Madison; and more has been promised by the Waukesha Memorial Hospital when its remodeling has been completed.

"Much more is still needed," Doctor Peters says. "They need office and hospital equipment, laundry facilities, stainless tableware—almost anything that can be used in a hospital."

"Just as important," he adds, "is the need for physicians and hospital staff personnel who would be willing to spend a few months, or even a few weeks, working in Nicaraguan hospitals." Doctor Peters asks that interested volunteers contact his office at the University of Wisconsin Medical Center (phone: [608] 262–2034).

Although Nicaragua and Wisconsin are almost identical in size, Nicaragua has only 525 physicians to nearly 5,000 in Wisconsin. With over 4,000,000 people, Wisconsin has almost three times the population of Nicaragua, but it has ten times more hospital beds.

Medical Museum Opened April 15

The first historic site to open its doors this season in Wisconsin was the Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien. The Museum, a three-building-recreation complex, is located on the site of the old Fort Crawford military post built in 1829.

Again this year, there are new and exciting exhibits to capture the tourists' interest. A huge new exhibit commemorates the 60th anniversary of the Wisconsin Anti-Tuberculosis Association.

Many exhibits trace the history of medical progress from Indian folklore to 20th century medicine which promises a life expectancy of 75 years to the average child born in Wisconsin today.

Near the end of the season last year, the 100,000th visitor was admitted to the Museum which is in its seventh year of operation.

The Museum, which is owned and operated by the CES Foundation of the State Medical Society, is open daily from 9 a.m. to 5 p.m. From July 4 through Labor Day, it also will be open daily until 9 p.m. The season closes Oct. 31.

Society Supports Handicapped Contest

The State Medical Society again this year helped support the Easter Seal Society's annual essay contest sponsored by the Governor's Committee on Employment of the Handicapped. Winners of the con-

test were honored guests at a luncheon Apr. 22 at the Park Motor Inn in Madison.

Open to all high school juniors and seniors, the contest attracted over 500 entries. Top winners in the statewide contest were Frank Ziegler, Marquette University High, Milwaukee, first, $200; William Abbott, Aquinas High, La Crosse, second, $150; James Bearss, Oshkosh High, Oshkosh, third, $100; Sharon Stein, St. Joseph Academy, Green Bay, fourth, $75; and Mary Pat Sheehan, Aquinas High, fifth, $50.

TB Association Contributes Historical Exhibit to Museum at Prairie du Chien

At an unveiling ceremony during the 60th anniversary conference of the Wisconsin Anti-Tuberculosis Association April 4–5 in Milwaukee, the State Medical Society accepted a TB historical exhibit for the Society's Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien. Accepting the exhibit was *Dr. W. D. Stovall*, Madison, president of the Society's Charitable, Educational and Scientific Foundation.

Old-time treatments for TB are shown, including a "bed warmer" once provided for all patients in fresh air sanatoriums during the winter. It consists of an electric bulb within a tin can. The patient was protected against burns by a cage of wooden spokes.

Contrary to public opinion, TB is not yet licked. About 100 Wisconsin people die each year of TB and 500 new active cases are discovered annually.

The Museum is open seven days a week through October 31. It is owned and operated by the CES Foundation.

Coin Collection Stolen from Society Lobby

Seventeen sets of proof coins valued at $1,000 were stolen from the lobby of the State Medical Society building early in April.

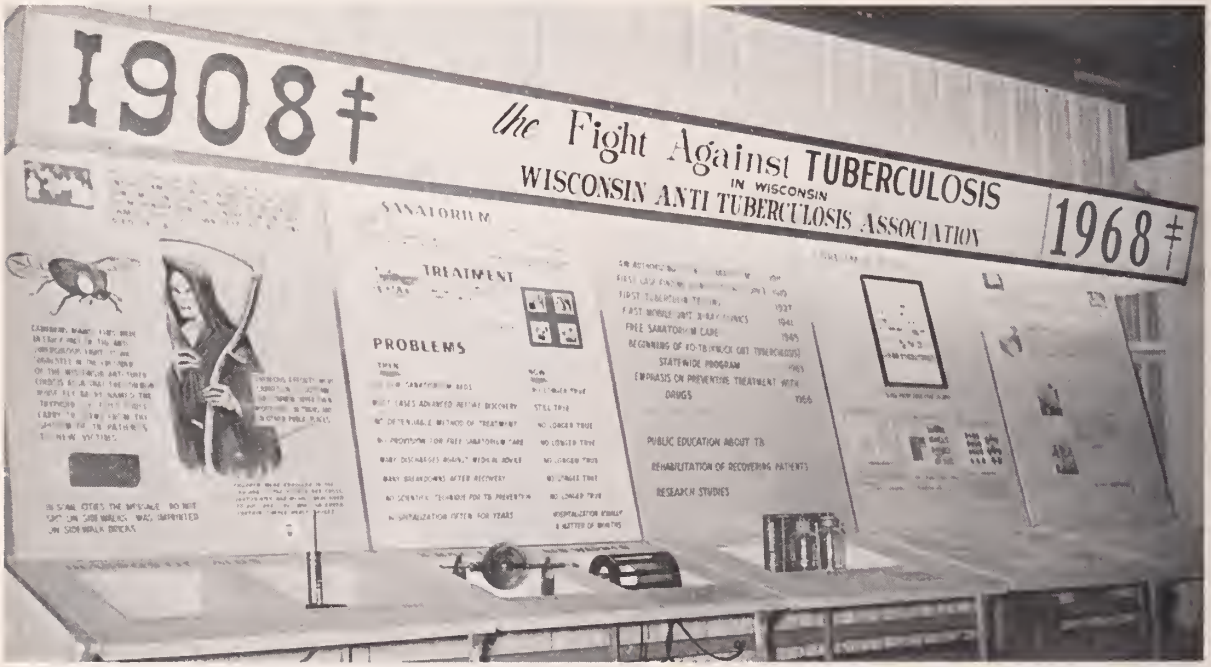
The Society, through auspices of the CES Foundation, has received these coins from donors who were helping the Foundation raise money for the Student Loan Fund. They were on display in hopes of attracting more gifts. When resold they would have helped "two or three medical students over their financial rough spots," according to Secretary Crownhart.

The coin collection is but one of many projects of the Foundation which continues to serve the medical profession through charitable, educational and scientific activities.

Auxiliary Has Medical Careers Day April 27

Over 200 Wisconsin high school juniors from 47 schools got a close-up view of careers in the health field during Medical Careers Day, Saturday, April 27.

Sponsored by the Woman's Auxiliary to the State Medical Society of Wisconsin, in cooperation with



THE HISTORY OF TUBERCULOSIS IN WISCONSIN is graphically told in a new exhibit this season at the Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien. The exhibit was contributed by the Wisconsin Anti-Tuberculosis Association. The huge new exhibit commemorates the 60th anniversary of WATA and its fight against TB. It dramatically shows how entire families were wiped out by TB at the turn of the century. In one instance, 22 members of a Wisconsin family in five generations died of what was then called consumption, according to Gordon Peckham, Museum curator.

the University of Wisconsin Medical Center, Medical Careers Day began with demonstration tours of various departments of University Hospitals in Madison. Students observed health professionals in actual work situations, and informational literature was distributed.

Students were then transported to the headquarters of the State Medical Society in Madison for lunch.

Highlight of the afternoon program at Society headquarters was a talk by Dr. Robert J. Samp, well-known Wisconsin physician and educator who previously has addressed thousands of high school students on the subject of smoking and cancer. His subject at this event was "Scientific Horizons—Unlimited."

Also featured were discussions of careers as licensed practical nurses and medical assistants by members of the staff of the Madison Area Technical College. Individual careers under consideration were occupational therapy, physical therapy, medicine, medical technology, x-ray technology, nursing, cytology, pharmacy, and dietetics.

State Groups Informed of Medical Museum and CES Foundation Work

Wisconsin residents have been learning about the contributions to public health through operation of the Museum of Medical Progress and the Society's Charitable, Educational and Scientific Foundation from staff members of the State Medical Society. More than 30 organizations throughout the state have sponsored addresses which point out the history of medicine through the ages and explain the continuing projects of the CES Foundation including the Student Loan Fund and the Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien.

THE WOMAN'S AUXILIARY to the Winnebago County Medical Society this spring was one of many groups who heard Society staff members explain the work of the CES Foundation and its projects. Mrs. E. J. Zmolek and Mrs. Charles R. Lyon of the Winnebago Auxiliary visit with Norman J. Salt, director of the Foundation, and Eric P. Jacobson, regional representative of the State Medical Society.

One of the staff speakers recently commented, "It is encouraging to know how attentive and interested the people are in medical history, its present trends, and its future goals." He added, "It helps to meet face-to-face with those who are anxious to help the Foundation continue its work."

Society's New Telephone System Installation Delayed by Strike

Because of a strike of comunications workers, completion of the new telephone system at Society headquarters has been delayed. The original switchover date of May 4 has now been set for June 25. When installation is complete, the new telephone number will be (area code 608) 257–6781. This number will serve all Society functions and allied organizations.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY HOME DURING THE MONTH OF APRIL 1968

2 Board of Trustees, Dane County Medical Society
2 Surgical Staff, Madison General Hospital
2 Madison Anesthesiology Society
2 Madison Urological Society
3 Planning Committee, Wisconsin Regional Medical Program
3 SMS Commission on Safe Transportation
6 SMS Executive Committee of Council
6 SMS Commission on Health Information
8 Department of Surgery, University Hospitals
11 Health Careers Advisory Committee and Board of Directors, Wisconsin Health Council
11 SMS Division on School Health
17 SMS Division on Vision
17 Legislative Committee, SMS Section on Ophthalmology
17 Judging of SMS Annual Photography Contest
18 Executive Committee, SMS Commission on Medical Care Plans
20 Annual Meeting, Wisconsin Association of Professions
21 Executive Board, Wisconsin State Medical Assistants Society
22 Madison Society of Obstetrics and Gynecology
23 SMS Third Councilor District Caucus
24 Advisory Committee, Wisconsin Regional Medical Program
25 Heart Study Committee, Wisconsin Regional Medical Program
27 Medical Careers Day

Meetings not held in the Society Home but which have a direct relationship are printed in italics, with the location in parentheses.

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and only a physician—only a professional diagnosis—can establish the etiology for a given patient. Then, if Conditioned Response Therapy is indicated, an Enuresis Alarm is best used under the physician's guidance. This is why S & L Enuresis Alarms are rented to patients **on prescription only.** S & L is the only nation-wide alarm rental service whch restricts itself to **prescription** rentals.

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Dr. Salibi Heads Neurosurgical Society

Dr. Bahij S. Salibi, neurosurgeon at the Marshfield Clinic, was inaugurated as president of the Central Neurosurgical Society at a meeting recently held in Chicago. In addition to his duties at the Marshfield Clinic, Doctor Salibi is a clinical assistant professor of neurological surgery at the University of Wisconsin Medical School, Madison, and an associate professor of neurological surgery at Cook County Graduate School of Medicine, Chicago.

Dr. Kenny at Green Bay

Dr. John A. Kenny recently became associated with *Dr. John R. Marnocha* in the practice of dermatology in Green Bay. Doctor Kenny graduated from Marquette University School of Medicine and took his internship at Los Angeles County General Hospital. He served in the United States Army Medical Corps and trained in dermatology at Wood Veterans Hospital, Milwaukee. He practiced in Kansas City, Mo., and served on the faculties of Kansas University School of Medicine and the University of Missouri Medical School. He is a member of the American Academy of Dermatology.

Dr. Claude Guest Speaker

Dr. John L. Claude, Oconomowoc, recently was the guest speaker at the Watertown Memorial Hospital Auxiliary meeting. Doctor Claude chose as the topic of his speech "The Menopause."

Dr. Uy Opens Office in Eagle

Dr. Mario Uy, Milwaukee, recently opened offices in Eagle. He graduated from Santo Tomas University, Manila, The Philippines, and has served as resident doctor at both Columbia and St. Mary's hospitals in Milwaukee. Eagle has been without a permanent physician for eight years.

Dr. Lokvam Guest Speaker

Dr. L. H. Lokvam, Kenosha, recently was the honored guest and speaker at the dinner meeting of the Kenosha County Medical Assistants Society. Doctor Lokvam recently returned from Vietnam where he served as a volunteer physician under the AMA's program, "Volunteer Physicians for Viet Nam."

Dr. Ellison Elected President

Dr. Edwin H. Ellison, professor and chairman of surgery at Marquette School of Medicine, Milwaukee, recently was elected president of the Central Surgical Association. He was secretary of the association from 1964–67.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Rudy Chosen Consultant

Dr. Warren B. Rudy, Racine physician with the Stahmer Clinic, recently was chosen as one of the physician consultants of the American Academy of Pediatrics to evaluate the medical aspects of Head Start programs in nearly 2,000 communities throughout the United States.

Dr. Dietsche Guest Speaker

Dr. Wolfgang O. W. Dietsche, Wisconsin Rapids, recently was the guest speaker at a meeting of the Riverview Auxiliary. Doctor Dietsche is a 1951 graduate of the University of Freiburg, Germany, and a fellow of the American Academy of Orthopedic Surgeons. His topic was on "Orthopedic Surgery."

Dr. Schrock Moves to Elkhorn

Dr. Joseph B. Schrock, Sharon physician for 19 years, will close his office on June 1 and move to Elkhorn. He will join *Drs. Henry R. Mol, Richard J. Rogers*, and *Roger D. Petersen* in the clinic at Elkhorn.

State Doctors Receive Honors

Eight Wisconsin men have been elected either fellows or associate members in the American Collegs of Physicians. Selected as fellows are *Drs. Joseph B. Grace*, Green Bay; *Gregory Inda*, Milwaukee; *George L. River*, Marshfield, and *James F. Hitselberger*, Fond du Lac. Associates are *Drs. Richard D. Fritz*, Glendale; *Joseph E. Geenen*, Racine; *Walter R. Sundstrom*, Madison, and *Fredric L. Hildebrand*, Menasha.

Dr. Keller Joins Medical Staff

Dr. Meredith Keller, Oshkosh, recently joined the staff of the Winnebago State Hospital. He graduated from the University of Texas Medical School and served four years in the United States Air Force. He was a health physician at the University of Texas A and M Health Center from 1962 to 1966. Since August 1966, he has been on the health center staff at Wisconsin State University, Oshkosh.

Dr. Graven Receives Markle Scholar

Dr. Stanley N. Graven, an assistant professor of pediatrics at the University of Wisconsin Medical School, Madison, recently was awarded the Markle Scholar Grant. The Scholar grants have been made annually since 1948 to relieve the faculty shortage in medical schools by giving aid to young teachers early in their careers. Doctor Graven also received recognition in the WISCONSIN STATE JOURNAL feature, "Know Your Madisonian," for his contribution to the community and for his work in developing the Hartford Laboratories which is an intensive care unit for sick or premature babies.

Dr. Bronson Guest Speaker

Dr. Frederick Bronson, Portage, recently was the guest speaker before a meeting of St. John's Luther Circle. Doctor Bronson, president of Columbia County Cancer Association, spoke on "Cancer—Facts and Figures."

Dr. Nishioka at Green Bay

Dr. Hiro Nishioka, formerly assistant professor of neurological surgery at the University of Iowa, is now associated with *Dr. Richard Oudenhoven*, Green Bay. Doctor Nishioka is certified by the American Board of Neurological Surgery, a fellow of the Royal College of Surgery of Canada, a fellow of the American College of Surgeons, and a member of the Harvey Cushing Society.

Dr. Garner Guest Speaker

Dr. Lawrence L. Garner, Wood, assistant chief of the Outpatient Service at the Veterans Administration Center, recently was the guest speaker at the Churchman's Brotherhood Meeting of the Emanuel Church, Hales Corners. His topic was entitled "Glaucoma—1968."

New Appointments at Marquette

Dr. James E. Youker, San Francisco, has been appointed professor and chairman of the Marquette School of Medicine Department of Radiology. He is an associate professor at the University of California Medical School and has been on the teaching staff since 1964. Doctor Youker is a 1954 graduate of the University of Buffalo School of Medicine and completed his internship and radiology residency training at the University of Minnesota. He spent six months in the pathology residency at Georgetown University, Washington, D. C. and served on the faculty of the Medical College of Virginia as an assistant professor from 1961 to 1963. Doctor Youker is a member of the Project Hope Committee and served as an attending radiologist for Hope in Indonesia in 1958. He is a member in the American College of Radiology, the Association of University Radiologists, and the International Society of Lymphology. He will assume his duties at Marquette on Sept. 1. Dr. John B. Alberti, formerly of the University of California, Los Angeles, has also joined the faculty as an assistant professor. He is a Marquette School of Medicine graduate, took his residency training at the University of Wisconsin, Madison, and a special fellowship in neuroradiology at the University of California. He was an assistant professor of radiology in residence at UCLA before coming to Marquette.

Dr. Bach Receives AHA Research Grant

Dr. Fritz H. Bach, an associate professor of medicine and medical genetics at the University of Wisconsin Medical School, Madison, recently received a fellowship from the American Heart Association to support his research toward the conquest of heart and blood vessel diseases. Doctor Bach graduated from the Harvard Medical School in 1960.

Dr. Holder Joins Clinic

Dr. Lynn W. Holder recently joined the staff at the Park Medical Clinic, Manitowoc. Doctor Holder recently was discharged from the United States Army Medical Corps after serving two years. He graduated from the University of Illinois College of Medicine and served his internship and residency at St. Luke Hospital, St. Louis, Mo.

Dr. Pulido at Rhinelander

Dr. Ernesto D. Pulido, a native of The Philippines, recently joined the staff of the Schiek Clinic, Rhinelander. Doctor Pulido was on the staff of the Swedish Hospital, Minneapolis, in the Department of Obstetrics and Gynecology, before coming to Rhinelander. He graduated from Far Eastern University in Manila and taught for one year in the Institute of Medicine before coming to this country in 1958. Doctor Pulido served a one-year internship in St. Barnabas Hospital, Minneapolis, and then interned at Highland Park General Hospital, Mich. He was a resident in obstetrics and gynecology at Swedish Hospital before completing his residency at Sinai Hospital, Baltimore.

Dr. Koch Leaves New Lisbon

Dr. Charles Koch, who has been associated with the Koch–Weston Clinic in New Lisbon since 1955, recently announced his decision to leave New Lisbon and to become associated with the Eugene Clinic in Eugene, Ore. He has been a member of the Tomah Memorial Hospital medical staff.

Dr. Beno Guest Speaker

Dr. Thomas J. Beno, Green Bay, recently was the guest speaker before the Woman's Hospital Auxiliary of Oconto Falls. Doctor Beno recently completed a three-month tour of duty in Vietnam.

Dr. Arendt Wins Skeet Honors

Dr. Charles Arendt, Wisconsin Rapids, recently won honors in the all-state annual Skeet Shooting Association meet. Doctor Arendt has won honorable mention for the third consecutive year.

Dr. Schleifer To Join Clinic

Dr. Philip J. Schleifer, Milwaukee, will join the Lakeland Medical Associates in the new doctors' clinic, Minocqua, in July. Doctor Schleifer graduated from Marquette University School of Medicine in 1967 and is completing his internship at Milwaukee Lutheran Hospital. Prior to entering medical school, Doctor Schleifer served with the 32nd Division of the United States Army in Berlin.

Dr. Williams Joins Marshfield Clinic

Dr. Mariella Fischer Williams, London, England, recently joined the staff of the Marshfield Clinic. Doctor Williams, the first woman to serve on the staff of the Clinic, was educated in England and is the author of numerous medical articles. She graduated from the School of Medicine of the Royal Colleges, Edinburgh, served as a neurologist at the Oxford Hospitals and at Birmingham Hospitals, England. She studied under Dr. Henri Gastau, a pioneer and one of the great names in neurology and electroencephalography. From 1961 to 1965, she served as an assistant professor of neurology at Wayne State University in Detroit and as a research associate and consultant neurologist at the Mayo Clinic, Rochester. For the past three years, she has been at the Manor Hospital, Epsom, England, where she was in routine patient care and also conducted a neurological survey of cases of mental retardation.

Dr. Bergmann Guest Speaker

Dr. F. T. Bergmann, Shawano, recently was the guest speaker before the Bonduel Rotary Club. He spoke on heart transplantations and the causes and reasons for the various problems involved.

Doctors Serve on Panel

Drs. Gerard Biedlingmaier, John W. Cornell, Jerome W. Fons, and *John J. Frederick*, all members of the Trinity Memorial medical staff, recently were panelists on a discussion called "Cancer and You." The program was part of the preventive medical care series, sponsored by the hospital, which started in 1967.

Doctors Appointed Consultants

Drs. Robert D. Bush, Manitowoc, *Stewart L. Griggs*, Green Bay, and *John B. Hughes*, Oshkosh, recently were appointed to be physician consultants by the American Academy of Pediatrics, in evaluating the medical aspects of Project Head Start. As consultants, the doctors will help plan Head Start medical programs and follow-ups, review medical aspects of Head Start applications, and maintain liaison with OEO regional offices.

Dr. Kurzon Guest Speaker

Dr. Alvin M. Kurzon, Glendale, recently has been holding a series of discussions at the Green Tree school, Glendale. The topic of discussions was of concern to parents in relation to educating youngsters to understand their own growing up, physical and emotional maturation, and problems common to various age groups.

Dr. Nevin Guest Speaker

Dr. I. Nik Nevin, Rhinelander, director of radiology, St. Mary's Hospital, recently was the guest speaker at the Cancer Crusade kickoff sponsored by the Oneida unit of the American Cancer Society in Rhinelander.

Dr. Meyer Heads Arthritis Group

DR. JULIUS M. MEYER of Milwaukee (right) became the first physician elected president of the Wisconsin Arthritis Foundation. The election took place in April during the Foundation's annual meeting which was attended by over 325 persons. Doctor Meyer, a specialist in internal medicine, presented outgoing president, Anthony M. Rood, Jr. with a desk set award in recognition of Mr. Rood's four terms as president of the Foundation.

St. Michael Hospital Medical Staff Named

Dr. Harold F. Ibach, chairman of the Department of Radiology at St. Michael Hospital, Milwaukee, was appointed chief-of-staff at the hospital, effective April 1. *Dr. Samuel Graziano* was appointed secretary–treasurer.

Doctor Ibach succeeds *Dr. John R. Evrard*, who remains on the executive committee of the St. Michael Hospital medical staff in the office of immediate past president.

Other newly appointed members of the executive committee are *Drs. F. L. DeGroat*, chief of Internal Medicine; *Samuel G. Perlson*, chief of Obstetrics; *Stanley N. Kenwood*, chief of Pediatrics; and *C. Hugh Hickey*, member-at-large.

Retaining their previous positions on the executive committee are *Drs. J. L. Teresi*, chief of Ancillary Services; S. R. Minkin, (D.D.S.), chief of Dentistry; *C. L. Berner*, chief of General Practice; *Dr. Lloyd F. Jenk*, chief of Psychiatry; and *Marvin Wagner*, chief of Surgery.

Dr. Pilliod New Chief-of-Staff

Dr. James V. Pilliod, Milwaukee, recently was elected chief-of-staff of West Allis Memorial hospital. Other officers named for the coming year were: *Drs. Harold J. Conlon*, Milwaukee, vice chief-of-staff; *DeLore Williams*, West Allis, chief-internal medicine; *Henry F. Twelmeyer*, Wauwatosa, chief-

surgery; *William W. Baird*, West Allis, chief-obstetrics and gynecology; *Ralph N. Olsen*, Wauwatosa, chief-pediatrics, and *Delbert L. Miner*, West Allis, chief-general practice.

Doctors Participate in Symposium

A symposium, held recently in Milwaukee, focused attention on the socio-moral problems of contraception and organ transplants. Featured speaker was *Dr. Sidney Shindell*, head of Marquette's Department of Preventive Medicine, who discussed the medico-legal problems of organ transplants. *Dr. Gerald A. Kerrigan*, dean of Marquette School of Medicine, introduced the session on organ transplants and *Dr. George E. Collentine, Jr.* president of The Medical Society of Milwaukee County welcomed the symposium group.

Physicians on Cancer Program

Dr. James R. Hoon of Sheboygan, president of the Wisconsin Division of the American Cancer Society, and *Dr. John K. Scott* of Madison, first vice-president, were speakers at the Second Annual Wisconsin Division Cured Cancer Assembly and 1968 Wisconsin Division Crusade Kickoff in Madison Mar. 30. Over 200 American Cancer Society volunteers and many persons cured of cancer were in attendance.

Dr. Guthrie Helps With Cancer Program

Almost 1,000 women attended a special program on the detection of breast and uterine cancer at the Vic Theater in Green Bay in March. The program was sponsored by the Brown County Unit of the American Cancer Society and the GREEN BAY PRESS–GAZETTE. *Dr. John M. Guthrie, Jr.*, Green Bay, answered questions from the audience following the showing of two films. Sponsors of the program were particularly pleased with the large turnout since they had anticipated an audience of 200.

Dr. Loftus Named to State TB Group

Dr. Edward R. Loftus of Winnebago was elected vice-president of the Wisconsin Anti-Tuberculosis Association at its 60th anniversary conference in Milwaukee Apr. 4–5. He also was reelected to the board of directors of WATA.

Further details of the WATA meeting appear in the PARAMEDICAL/ANCILLARY section of this issue.

IS CURRENT GRADUATE TRAINING IN SURGERY ADEQUATELY TAILORED TO THE NEEDS OF THE MODERN SURGEON?

James H. Casey, M.D., Ph.D., made a survey of surgical practice in Wisconsin. Replies to his poll came from 39 Milwaukee surgeons (designated urban) and 70 Wisconsin surgeons outside of Milwaukee (designated rural). The report was published in *Surgical Clinics of North America*, December 1967.

Doctor Casey concluded with the summary:

1. The term "General Surgeon" is out of date but has not been discarded for lack of a more suitable title. The practice of the modern surgeon is not general but is quite specifically limited to surgery of the abdomen, vascular system, head and neck, and proctology.

2. Orthopedics, urology, and neurosurgery combined make up only 4 per cent of surgical practice by Diplomates of the American Board of Surgery in Wisconsin. There is little difference between urban and rural surgery.

3. Gynecology is an important component of rural surgical practice, but makes up a negligible portion of urban surgical practice.

4. Vascular surgery and thoracic surgery appear to be becoming more important components of surgical practice.

5. Rotation through orthopedics, urology, and neurosurgery should be eliminated from surgery training programs and that time saved should be spent in research or clinical work in abdominal, breast, head and neck, vascular, thoracic, or proctologic surgery. An elective period on gynecology could be maintained.—V. S. FALK, M.D., Edgerton

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Doctor Casey was Assistant Clinical Professor of Surgery, Marquette School of Medicine. His current address is: 1525 Superior St., Newport Beach, Calif.

GUIDELINES FOR USE IN HEARING CONSERVATION AND NOISE CONTROL PROGRAMS FOR INDUSTRIAL WORKERS

To meet the need for reliable noise criteria for use in hearing conservation and noise control programs for industrial workers, a set of guidelines has been developed by an Inter-Society Committee of industrial physicians and industrial hygienists. These data represent the first attempt to extract and condense pertinent information from various scientific literature sources into a meaningful and authoritative guide for the protection of hearing of industrial workers.

Dr. Meyer S. Fox of Milwaukee was a member of the Inter-Society Committee.

Copies of the report, entitled, "Guidelines for Noise Exposure Control," are available at 30¢ each from the Industrial Medical Association, 55 East Washington St., Chicago, Ill. 60602.

EAU CLAIRE–DUNN–PEPIN

Members Meet at Lorenz Institute

Members of the Tri-County Medical Society and its Woman's Auxiliary met in an interesting and unusual atmosphere for their March meeting. The scene was the Albert A. Lorenz Institute, Eau Claire's new residential treatment center and hospital for children and adolescents with emotional problems.

Dr. Harry Gonlag, vice-president of the medical society, presided at the business meeting in the absence of *Dr. William T. Mautz. Dr. Lou A. Raymond* is secretary-treasurer.

About 40 members of the Auxiliary met in the reception area of the Institute following the dinner. Activities of this group include a scholarship offered annually to a student in the allied medical field and a tea for the graduating class of the School of Nursing at Wisconsin State University, Eau Claire. This year's event was held in May at the home of Mrs. William J. Beckfield.

Auxiliary officers include Mrs. Emil Schulz, president; Mrs. William Walter, president-elect; Mrs. Harry Thimke, secretary, and Mrs. Charles Ihle, treasurer, all of Eau Claire.

Guests at the dinner meeting included Mrs. Louise Britton, president of the State Medical Society Auxiliary, and Mrs. Leona Chesemore, staff secretary to the Auxiliary, both from Madison, and Mrs. Barbara Sargeant, president-elect, from Milwaukee.

Approximately 135 persons attended and were guided on tours by the 36-member staff of the Institute, located in the old Sacred Heart Hospital which has been extensively remodeled and modernized. Following tours of the classrooms, therapy rooms, offices of the staff, kitchen facilities and living quarters of the children, a buffet supper was served in the gym by the young patients ranging in age from 11 to 17.

Dr. Albert A. Lorenz, director of the Institute and head of its department of psychiatry, explained the purpose and function of the facility and described cases of some of the patients. He stated that in all cases, the children had been patients at other facilities but predicted that they would receive a broader range of treatment and education on an individual level at the Institute at less cost over a period of time. Resources of the community are used wherever feasible for the care of the patient and the intention of the program is to avoid the "dehumanization" of the patient and to prepare him in every way for returning to home and community. He effectively traced childhood behavioral problems from the former "withdrawal," so common in the past, to the current "acting out" behavior of today.

Unique in administration, the facility has on its teaching staff two Catholic nuns working with a Methodist minister, Arthur E. Haerle, who is program coordinator for the Institute and former assistant minister at Lake Street Methodist Church in Eau Claire. Walter R. Conner is the assistant director and head of the department of Social Services and the staff of the Northwest Psychiatric Clinic at Eau Claire is utilized in therapeutic services while others of the medical profession in the area serve as consultants.

Physicians whose names appear in italics are members of the State Medical Society.

ROCK

Dr. Callan Discusses Doctors' Problems

The former speaker of the House of Delegates of the State Medical Society, *Dr. Robert E. Callan* of Milwaukee, discussed problems of individual physicians and organized medicine at the Mar. 26 meeting of the Rock County Medical Society. Twenty-three members attended the meeting held at the Elks Club in Beloit.

WOOD

Medical Practice and the Federal Government Discussed

Forty-seven members of the Wood County Medical Society met Mar. 7 at the Westview Country Club in Marshfield. Medical practice as desired by the federal government was discussed by *Dr. Russell F. Lewis, Jr.* of Marshfield.

KENOSHA

Illinois Cardiovascular Specialist Speaks

Dr. Sheldon H. Steiner of Northwestern University Medical School and Director of the Cardiovascular Research Laboratory at Wesley Memorial Hospital, Chicago, spoke to 46 members of the Kenosha County Medical Society Apr. 4 at the Elks Club in Kenosha. He spoke on Evaluation of Rheumatic Valvular Disease and Current Methods of Prosthetic Valve Replacement.

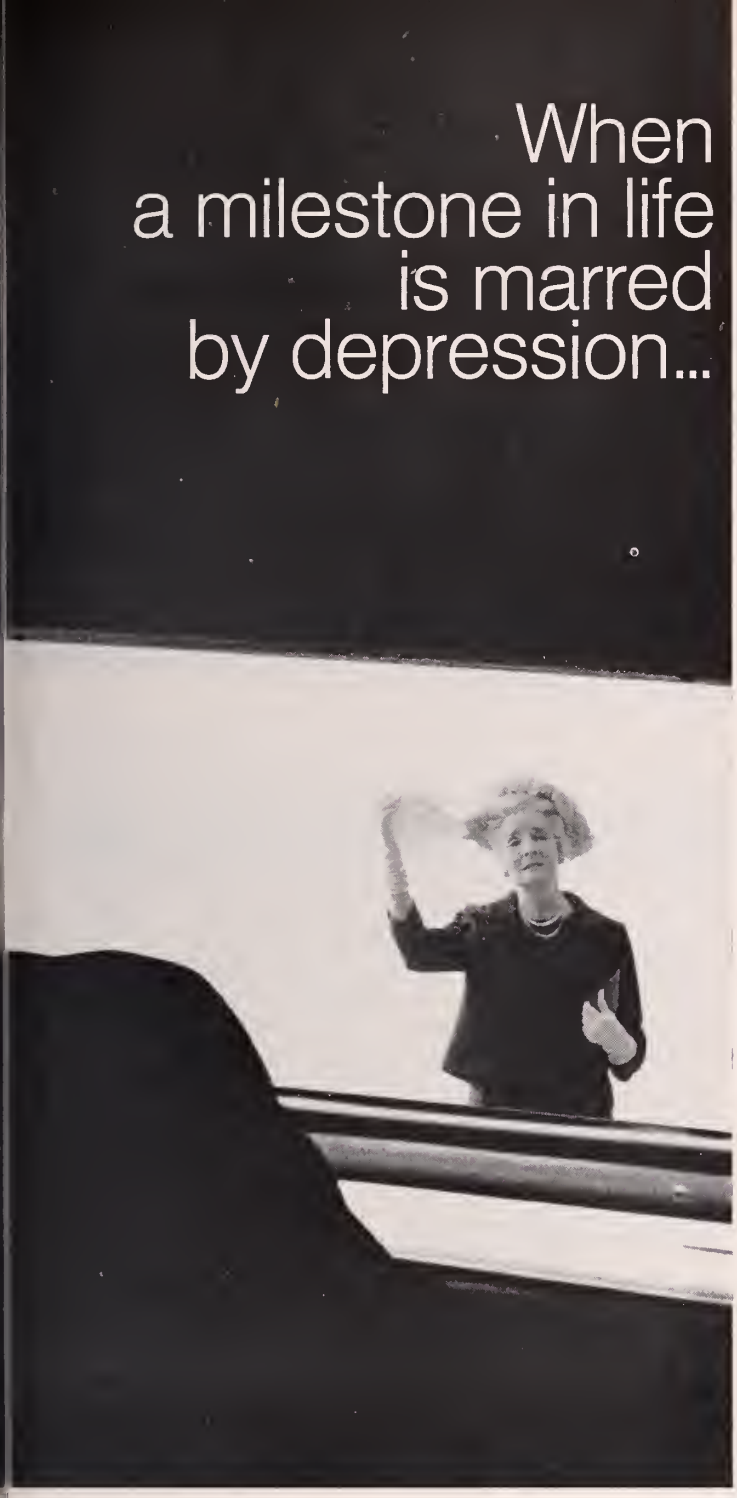
OCONTO

Sex Education Needed for Youth

Members of the Oconto County Medical Society, meeting Mar. 26 in Oconto, agreed unanimously that there is a need for a sex education program for Oconto county youth. Thus, the physicians will investigate the feasibility of implementing such a program. A film strip, "Sex Education USA," was viewed and approved by the society members for showings to interested groups.

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyper thyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 ye of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, d turbances of accommodation, swea ing, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and dis orientation), activation of psychosis schizophrenics and agitation (inclu

When a milestone in life is marred by depression...



Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by depression with such symptoms as feelings of sadness, incapacity, helplessness and hopelessness.

Tofrānil often relieves symptoms of depression.

As maintenance therapy during the active phase of depression, it may help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

In patients with cardiovascular disease, hyperthyroidism or increased intraocular pressure; or in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication, or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy, the special precautions listed in the prescribing information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the full prescribing information.

Tofrānil® imipramine hydrochloride Geigy

ypomanic and manic episodes)
h may require dosage reduction
'or addition of a tranquilizer or
orary discontinuation of the drug,
eptiform seizures, orthostatic
tension and substantial blood
sure fall in hypertensive patients,
ura, transient jaundice, bone mar-
depression including agranulocy-
, sensitization and skin rash
ding photosensitization, eosino-
a, and mild withdrawal symptoms
udden discontinuation after pro-
ed treatment with high doses.
asional hormonal effects (im-
nce, decreased libido, and estro-
c effects) may be observed.
pine-like effects may be more
ounced (e.g. paralytic ileus) in
eptible patients and in those
anticholinergic agents (includ-
ntiparkinsonism drugs).
atient Adult Dosage: Initially,
g. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
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SPECIALTY SOCIETIES

Milwaukee Gynecological Society

At the recent annual meeting of the Milwaukee Gynecological Society *Dr. John R. Evrard* of Milwaukee was elected president for the coming year. Elected president-elect to take office in 1969 was *Dr. William J. Madden* of Racine. *Dr. Samuel G. Perlson* of Milwaukee was elected to a two-year term as secretary-treasurer. The Milwaukee Gynecological Society has a membership of 109 board certified and board eligible surgeons in the field of obstetrics and gynecology in the Milwaukee area.

Milwaukee Academy of Medicine

Dr. Harvey C. Knowles, Jr. of Cincinnati was guest speaker Apr. 16 at the 942nd meeting of the Milwaukee Academy of Medicine. His subject was "The Problem of Diabetes Control and the Progression of Vascular Disease." Doctor Knowles is in the Department of Internal Medicine, University of Cincinnati College of Medicine.

Wisconsin Society of Pathologists

The mid-year (Spring) meeting of the Wisconsin Society of Pathologists will be held June 7–9 at Eagle Rivers Resort, Eagle River.

The scientific program will be held on Saturday, June 8. There will be a morning presentation of scientific papers by members and residents. An afternoon seminar on Pitfalls in Dermatopathologic Diagnosis will be moderated by Dr. Arthur C. Allen, Jewish Hospital, Brooklyn, N. Y. The day will conclude with a meeting of the Board of Directors, followed by dinner.

Physicians whose names appear in italics are members of the State Medical Society.

WISCONSIN'S HEALTH by E. H. JORRIS, M.D., State Health Officer

ORAL CYTOLOGY PROGRAM REVEALS MOUTH CANCER

A two-year demonstration program has ended which made available to dentists in Wisconsin a method to test the effectiveness of cytological smears as a means of early detection of oral cancer.

Of the 16,000 new cases of mouth cancer diagnosed each year in the United States, two out of three die of the disease and many of those who survive are disfigured or disabled. In 1966, 7,000 Americans died of cancer of the oral cavity.

In Wisconsin, as in the nation, cancer ranks second to heart disease as the leading cause of death. Wisconsin had an average of 134 deaths per year for the last ten years from oral cancer, and 138 deaths last year. A man's chances of having mouth cancer are twice those of a woman. In Wisconsin each year for the last ten years 8 of every 10 oral cancer deaths were males.

Dentists are in a particularly strategic position to find pre-cancerous oral lesions and mouth cancers in the early stages of their development. In recent years, in the United States, efforts have been made to enlist the dental profession in the search for mouth cancer.

The oral cytology program was started late in 1965 jointly by the Dental Health Section of the Wisconsin Division of Health, Wisconsin State Dental Society, American Cancer Society, and State Laboratory of Hygiene.

An oral cytology kit was sent to each practicing dentist in Wisconsin and each was asked to take oral cytological smears whenever he noticed a suspicious condition in any of his patients.

During the program approximately 290 dentists (14%) in Wisconsin sent 514 smears to the laboratories for diagnosis. Among them, there were 46 abnormal readings of which six smears revealed cancer.

The bulk of the smears were taken from patients 30 to 34 and 70 to 74, with most positive smears, percentagewise, coming from those 45 to 49 years old.

Discovered early, 80 to 90% of oral cancer can be cured. Unfortunately, the dentists see only 40% of the population. Therefore, a statewide educational program is necessary to alert the people in Wisconsin to the need for periodic mouth examinations.

* * *

PANEL OF DOCTORS PROPOSED TO EVALUATE CRASH INJURIES

Establishment of an impartial medical panel of doctors to determine the extent of injuries sustained in automobile accidents was one of the methods suggested by an insurance company executive to control further increases in insurance costs. Jack Doucette, secretary of the Milwaukee Mutual Insurance company, told the Sheboygan Rotary Club in March.

He predicted the entire approach to auto insurance would be changed in the next three to five years to meet the social need at a cost the public can afford. Mr. Doucette urged Rotarians to support highway safety legislation.

Marshfield Clinic Foundation Program

A visiting science program was held at the Marshfield Clinic in late March. The two-day program was conducted by Dr. David A. Dreiling, chief of surgery at Elmhurst Affiliate Mount Sinai Hospital in New York City. The program was sponsored by the Marshfield Clinic Foundation for Medical Education and Research.

Public Heart Forum at Sheboygan

Two Wisconsin specialists in the field of heart disease treatment were featured in a special Public Heart Forum presented Apr. 17 in Sheboygan. Entitled "Surgical Opportunities for the Treatment of Heart Disease," the program was moderated by *Dr. Donald M. Rowe* of Kohler, medical director of the Kohler Company.

Dr. Mischa J. Lustok, eminent cardiologist and director of the Cardiovascular Disease Center at Mt. Sinai Hospital, Milwaukee, and *Dr. William P. Young*, chief of the Cardiovascular Surgery division of the University Hospitals in Madison, presented the program which was followed by questions from the audience.

Gundersen Clinic Photographer Winner

The medical photographer for the Gundersen Clinic and La Crosse Lutheran Hospital has been awarded second place in the professional photography division of the 10th annual Student American Medical Association–Eaton Medical Art Salon competition. Joseph N. Tiedt of La Crosse received $150 and a trophy for his color photograph showing cancer of the tongue. His photo is part of the medical art salon which will be touring hospitals and medical schools throughout the United States. The tour includes a showing at the June convention of the American Medical Association in San Francisco. Mr. Tiedt has placed among the top entrants the past four years. He has been medical photographer at the Gundersen Clinic for six years. He was employed in the photography department of University Hospitals, Madison, before going to La Crosse.

Wisconsin Anti-Tuberculosis Association

"There's a pill to prevent TB," was the theme of the Wisconsin Anti-Tuberculosis Association's 60th anniversary conference on TB, held Apr. 4–5 in Milwaukee.

Several top level speakers appeared on the program. Mrs. Shirley H. Ferebee, chief of the research section of the U. S. public health service TB program; Dr. Francis J. Curry, assistant director of public health for the San Francisco department of public health; Frances T. Koonz, RN, director of the nursing advisory service of the National TB Association and National League of Nursing; John E. Egdorf, executive director of the Tuberculosis Institute of Chicago and Cook County; and J. Martin Klotsche, PhD, chancellor of the University of Wisconsin–Milwaukee.

Unveiling of the TB historical exhibit contributed by the WATA to the State Medical Society of Wisconsin's Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien took place at the anniversary dinner. Details of this event appear in the STATE MEDICAL SOCIETY section of this issue.

Doctor Curry reported on the unprecedented success of an isoniazid TB prevention program begun in 1958 among San Francisco school children. Mrs. Ferebee discussed the increasingly important question of whether INH should be given only to "high-risk" tuberculin reactors or to all reactors. And Miss Koonz focused attention on the problem of how to make preventive programs as appealing as curative programs.

Because there is a pill to prevent TB and because tuberculosis can be eradicated if INH is prescribed as fully as its potential suggests, the meeting also featured a panel discussion of some pioneering TB prevention programs already underway in Wisconsin. These include programs in industry, in a high-incidence population, in private medical practice, and in an outpatient dispensary. Members of the panel included *Dr. Donald M. Rowe*, medical director of the Kohler company, Kohler, and *Dr. Frank C. Stiles*, Monroe, chairman of the Wisconsin chapter of the American Academy of Pediatrics.

Doctor Klotsche examined some of the root causes of problems facing urban centers and ways in which communities should move to solve them.

A resolution of the association pointed out that programs of the WATA in the past four years have brought a new dimension to the tuberculosis campaign in the state. More than 200,000 persons in all age groups have been tuberculin tested and x-rayed.

It was also revealed at the meeting that added impetus has been given to expansion of outpatient departments of sanatoriums, and interest by physicians in private practice increased in utilization of chemoprophylaxis. All other interested agencies have been alerted to the opportunity and obligation of tuberculosis prevention, it was reported.

WRMP Hosts Nursing Workshop

The Wisconsin Regional Medical Program was host to a three-day national workshop for nursing at the Wisconsin Center, Madison, Mar. 25–27. Cooperating with the Wisconsin Regional Medical Program in this project were the National League

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Physicians whose names appear in italics are members of the State Medical Society.

for Nursing and the Division of Regional Medical Programs, National Institutes of Health, Bethesda, Maryland. Spearheading the planning was Martha R. Jenny, Coordinator for Nursing in the Wisconsin program.

Representatives from more than 30 Regional Medical Programs in the United States attended the three-day session.

Since the chief goal of all Regional Medical Programs is to improve prevention, diagnosis, treatment and rehabilitation of cancer, heart disease, stroke and related diseases, the Conference centered on the role of nursing in areas of primary concern such as the delivery of nursing services to patients, improving and extending nursing skills, utilization of nurse manpower and resources, and cooperative and collaborative approaches to planning.

Participating in the program were *Dr. John S. Hirschboeck*, coordinator, the Wisconsin Regional Medical Program, Inc.; Valencia Prock, associate professor of Public Health Nursing, University of Wisconsin; Signe S. Cooper, professor of nursing, University of Wisconsin Extension, Department of Nursing; Sister M. Thomas, dean, Marquette University School of Nursing; Dona Gilbo, instructor, medical-surgical, University of Wisconsin School of Nursing; Katharine Lembright, American Heart Association; Ivelda Artz, Nursing Consultant, Coronary Care, United States Public Health Service; Beatrice Chase, director, Community Planning for Nursing, National League for Nursing;

Veronica Conley, Chief, Allied Health Section, Continuing Education & Training Branch, National Institutes of Health; Florence J. Ullman, Neurological Diseases and Stroke, Bureau of Environmental Control and Disease Prevention; Jerry R. Weston, nurse consultant, Cancer Control, Bureau of Environmental Control and Disease Prevention; Alice Weldy, Executive Secretary, Wisconsin Nurses Association;

Florence Reynolds, Information Officer, Division of Nursing, United States Public Health Service; Elizabeth Harmon, Program Coordinator, Division of Medical–Surgical Nursing, American Nurses Association; and Dr. Margaret Sloan, Associate Director for Organization Liaison, Division of Regional Medical Programs, National Institutes of Health.

Dr. Robert Marston, director, Division of Regional Medical Programs, National Institutes of Health, spoke to the participants via telephone from Bethesda, Md.

* * *

FADS, MYTHS, QUACKS—AND YOUR HEALTH: Public Affairs Pamphlet No. 415 by Jacqueline Seaver. Available for 25¢ from the Public Affairs Committee, a nonprofit educational organization, 381 Park Avenue South, New York, N. Y. 10016.

Dr. Kief Addresses Medical Assistants

Dr. Harold J. Kief of Fond du Lac, president of the State Medical Society, addressed members of the Wisconsin State Medical Assistants Society Feb. 3 at its Ninth Educational Symposium in Milwaukee. Also in the picture above are Miss Edith Murphy of Milwaukee, chairman of the Symposium, and Miss Donna Schultz of Appleton, president of the WSMAS. A report of the meeting appeared in the March issue.

CLINICAL CENTER STUDIES OF BILIRUBIN METABOLISM

The cooperation of physicians is requested in the referral of patients with hyperbilirubinemia for studies of bilirubin metabolism being conducted by the Metabolism Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Of particular interest are patients with chronic or intermittent unconjugated hyperbilirubinemia, in whom the diagnosis of hemolysis, Gilbert's syndrome, or a post-hepatitic syndrome is suggested. Patients with conjugated or mixed hyperbilirubinemia (e.g., Rotor's syndrome or Dubin–Johnson syndrome) in whom obvious obstructive or active inflammatory disease has been ruled out, are also needed. A few patients with stable, compensated cirrhosis of the liver may also be accepted for study.

Selected patients will be admitted to the Clinical Center as inpatients for a minimum period of two weeks. Isotopic bilirubin clearance and red blood cell life-span studies, as well as dye clearance studies, will be performed. Liver biopsy may be performed in selected situations. Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to these studies may write or telephone: Paul D. Berk, M.D., Clinical Center, Room 4-N-117, National Institutes of Health, Bethesda, Md. 20014; telephone: 656–4000, ext. 65955 (Area Code 301).

* * *

UNDER THE 1967 amendments to the social security law, a disabled widow whose husband worked long enough can receive monthly benefits as early as age 50.

OBITUARIES

Dr. Lester M. Gorenstein, 55, former La Crosse physician died Feb. 25, 1968, in Fort Myers, Fla.

Doctor Gorenstein graduated from the Marquette University School of Medicine in 1938 and served his internship and residency at Milwaukee County General Hospital. He served two years in the United States Army as a battalion surgeon with the 12th Armored Division before coming to La Crosse in 1946. In 1954, he did postgraduate work at the University of Indiana Medical Center in Indianapolis and in 1957 he concluded his studies at the University of Colorado at Denver. In 1959, he was chief-of-staff at St. Francis Hospital in La Crosse. Doctor Gorenstein was a consultant with the State Department of Public Welfare, was director of the Winneshiek County Child Guidance Clinic, Decorah, Iowa and worked with the La Crosse County Guidance Clinic. He was also chairman of the professional advisory committee, La Crosse County Association for Mental Health for two years. While at the Wisconsin Child Center in Sparta, as a consultant, Doctor Gorenstein and the management of the center were engaged in controversy over policy and professional handling of child residents. He resigned his position and in 1965, in an interview, Doctor Gorenstein stated, "that the center had made remarkable progress in resolving this situation."

He was a member of the American Psychiatric Association, former president of La Crosse County Medical Society, member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, the former Ruth Sherkow of Milwaukee, and a son, Ralph, Fox Point.

Dr. Desanka Stampar, 85, a well-known Yugoslavian pediatrician and pioneer in public health service, died Mar. 5, 1968, in Madison.

Doctor Stampar received academic degrees in Austria and Czechoslovakia, and attended the Harvard University School of Public Health. Her husband, Dr. Andrija Stampar, who died in 1958, was a former president of the World Health Organization.

Dr. Oscar Knutson, 80, Osseo, died Mar. 10, 1968, in Eau Claire.

He was born May 1, 1882 in Kewaunee County and graduated from the Wisconsin Physicians and Surgeons College (now Marquette) in 1905. He began his practice in Dallas, and later moved to Osseo in 1913 where he practiced for 55 years. In 1962 Doctor Knutson was honored by his many friends at a banquet in recognition of 50 years of service and devotion to the people of the Osseo area.

He was elected to life membership in The State Medical Society of Wisconsin in 1960. He was also a member of Eau Claire–Dunn–Pepin County Medical Society and American Medical Association.

He is survived by four nephews and one niece. His wife preceded him in death in 1935.

Dr. Kenneth C. Kehl, 63, Racine, died Mar. 11, 1968, in Racine.

Doctor Kehl graduated from the University of Wisconsin and Washington University Medical School, St. Louis, in 1932, and interned at Strong Memorial Hospital, Rochester. His residency was taken at University Hospital, Ann Arbor, Mich. Doctor Kehl had practiced internal medicine in Racine since 1934. He served on the staffs of St. Mary's and St. Luke's hospitals.

Doctor Kehl was a member of the Racine County Medical Society, State Medical Society of Wisconsin, American Medical Association, American College of Physicians and Milwaukee Academy of Medicine.

Surviving are his widow, Franzel, and a son, Kenneth George, at home. A daughter, Elsa Janet, preceded him in death Mar. 16, 1966.

Dr. Walter W. Stebbins, 93, retired Madison physician, died Mar. 12, 1968, in St. Petersburg, Fla.

Born in Little Falls, N. Y., July 28, 1874, Doctor Stebbins attended Cornell University and graduated from the Bellevue Hospital Medical College in 1898. He interned at the Metropolitan Hospital, New York City. He began his practice of general medicine in Green Bay in 1900, continued it in Mt. Vernon from 1901–1908. He then practiced in Verona until 1917 when he moved to Madison. He was Madison city health officer during World War I.

He was long an enthusiastic advocate of regular exercise, including handball and swimming, as aids to health. In 1941, Doctor Stebbins was acclaimed the first physician in the world to try the vitamin C treatment for increasing man's "virility."

In 1964, he was featured in the CAPITAL TIMES for his own physical fitness program. For several years he had spent his winters in Florida.

Doctor Stebbins was honored with a lifetime membership in the State Medical Society of Wisconsin in 1950. He was also a member of the Dane County Medical Society and American Medical Association. He was an honorary member of the Madison General Hospital medical staff which in 1956 gave him a testimonial dinner for long loyalty and service.

Surviving are a son, Dr. George G. Stebbins, Madison; and two daughters, Mrs. G. William Longenecker, Madison; and Mrs. Cecil W. Hoyt, Cottage Grove.

Dr. Clement F. Neacy, 67, former Milwaukee physician, died Mar. 19, 1968, in Palos Verdes, Calif.

Doctor Neacy graduated from Rush Medical College, University of Chicago in 1930. He served in

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OBITUARIES *continued*

the United States Army during World War I from 1918 to 1919 and reentered service in 1942 when he was commissioned a Commander in the United States Navy. Doctor Neacy was discharged in February 1946 after being in active duty in World War II.

Surviving is his widow, Alice, and a daughter, Kit.

Dr. John H. Houghton, 60, Wisconsin Dells, former president of the State Medical Society of Wisconsin, died Mar. 25, 1968, in Baraboo.

Doctor Houghton graduated from the Marquette University School of Medicine in 1932 and served his internship at Milwaukee County Hospital. In 1936, he left his practice in Wisconsin Dells and attended the University of Pennsylvania Post-Graduate School of Medicine. In 1937 he returned to Milwaukee and did residency work in surgery at St. Joseph's Hospital.

Doctor Houghton served as president of the Columbia–Marquette–Adams County Medical Society in 1950 and 1952, respectively. He served on a Special President's Committee on the Medical Care Survey, was councilor for the third district from 1956 until 1963, and was a member of the Society's Commission on Medical Care Plans. He served as president of the State Medical Society from 1965 to 1966, at which time he was appointed to a seven-year term to the State Board of Health, now Council on Health of the State Department of Health and Social Services, by Governor Warren P. Knowles. He was also a member of the American Medical Association.

Doctor Houghton recently endowed a grant to the State Medical Society's Charitable, Educational and Scientific Foundation so that an annual award could be made to deserving students of medicine associated with a Wisconsin medical school. (Also see editorial in April issue at page 235—Ed.)

Surviving are his widow, Elsie; a daughter, Mrs. Robert Whittaker, Honolulu, Hawaii; a son, John, Reedsburg; and a brother, Dr. William Houghton, Milwaukee.

Dr. Christoph C. Reinke, 76, Milwaukee general practitioner for 45 years, died Mar. 29, 1968.

Doctor Reinke graduated from the Marquette University School of Medicine in 1922. An avid sports fan, he was the team physician at South Division high school for 42 years and coached in his early years. For his athletic achievements, Doctor Reinke was elected to South Division's Hall of Fame in 1950.

He was a member of the Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. Doctor Reinke served in the United States Army Medical Corps in World War I and was also a member of the American Academy of General Practice.

Surviving are two sons, Christoph, Jr. and John of Milwaukee.

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 67, No. 6 JUNE 1968

SCIENTIFIC ARTICLES

Some Clinical Expressions of Antibody Deficiency and Autoimmune Reactions, by William S. Middleton, M.D., Madison ---- 289

Perforation of a Duodenal Diverticulum; case report, by Henry S. Waters, M.D. and Ethan D. Pfefferkorn, M.D., Marshfield -- 294

Comments on Treatment: Adrenergic Receptors and the Physician, by Pitambar Somani, M.D., Ph.D., Milwaukee --------- 296

Therapeutic Dilemmas: Legal and Moral Problems of Emergency Care (No. 8 of a Series), by Harry Beckman, M.D., Milwaukee ---------- 300

SPECIAL FEATURES

President's Message to the House of Delegates: State Medical Society, by William D. James, M.D., Oconomowoc -------- 287

Narcotics Registration Deadline is July 1 -- 295

James O. Kelley, Executive Secretary, Celebrates 30th Anniversary with Milwaukee Medical Society ---------- 306

Medical Memo: Museum of Medical Progress and Stovall Hall of Health ---------- 22

New Workmen's Compensation Rules ------ 28

Wisconsin's Health: Radiation Monitors Ready and Able, by E. H. Jorris, M.D., State Health Officer ---------- 36

EDITORIALS

The Commodity and the Cost ---------- 305

Carl N. Neupert, M.D. ---------- 307

REGULAR FEATURES

Publication Information ---------- 7

Medical Meetings ---------- 8

The Medical Student Forum ---------- 308

Medical Green Sheet ---------- 309

State Medical Society ---------- 23

Physician News ---------- 25

County Societies ---------- 33

Section on Ophthalmology ---------- 35

Specialty Societies ---------- 36

Paramedical/Ancillary ---------- 47

Obituaries ---------- 51

Society Records ---------- 53

Bookshelf ---------- 57

Physicians Exchange ---------- 58

Index to Advertisers ---------- 60

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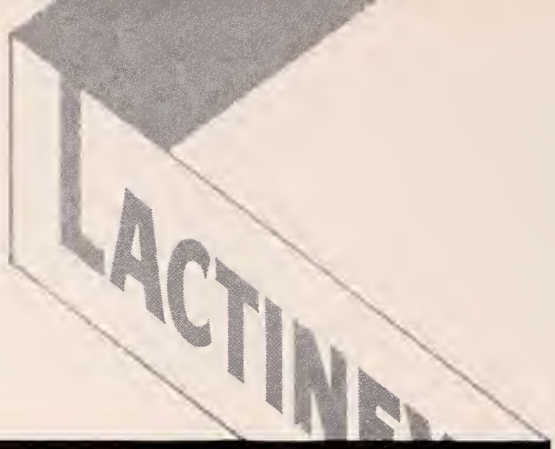
Journal
Established 1903

Annual Subscription ------$10.00
Single Copy ---------- 1.50
Previous Years' --------- 3.00
January Blue Book ------ 5.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago, Illinois 60610; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin 54481.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.



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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 WISCONSIN

Aug. 22–24: Wisconsin "Cancer Chemotherapy 1968" conference course for physicians, Division of Clinical Oncology, University of Wisconsin Hospitals, Madison.

Aug. 22–24: Workshop on "Exercise as a Therapeutic Tool in Coronary Heart Disease," University of Wisconsin Medical Center and the University Extension in conjunction with the Department of Physical Education—Men, Madison.

Sept. 12–14: Fall meeting, Wisconsin Society of Internal Medicine, Oshkosh, at The Pioneer.

Sept. 14–15 (tentative): Fall meeting, Wisconsin Otolaryngological Society.

Sept. 14–15: Fall meeting, Wisconsin Society of Anesthesiologists, Lake Geneva, at the Playboy Club.

Sept. 20–22: Fall meeting, Wisconsin Radiological Society, Lake Geneva, at the Playboy Club.

Sept. 21: Fall meeting, Wisconsin Surgical Society, St. Mary's Hospital, Madison.

Sept. 25: 1968 Wisconsin Heart Association–Adolf Gundersen Medical Foundation Symposium on Hypertension, Wisconsin State University at La Crosse.

Sept. 25–26: Annual meeting, Wisconsin Academy of General Practice, Pfister Hotel, Milwaukee.

Oct. 1–4: Sixth annual Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Oct. 2: Pulmonary Thromboembolism Conference, sponsored by The Wisconsin Regional Medical Program, Coffey Auditorium, Milwaukee County Hospital, Milwaukee.

Oct. 3: Pulmonary Thromboembolism Conference, sponsored by The Wisconsin Regional Medical Program, Employers Insurance Company of Wausau, Wausau.

Oct. 5: 14th Annual Fall Cancer Conference (The Cancer Scrimmage), University of Wisconsin Medical Center, Madison.

Oct. 8–11: Meeting of the Wisconsin Nurses Association, Sheraton–Schroeder Hotel, Milwaukee.

Oct. 9–10: Meeting of Wisconsin Division, American Cancer Society, Oshkosh.

Nov. 16: Fall annual meeting of Wisconsin Society of Pathologists, Marquette School of Medicine, Milwaukee.

1968 NEIGHBORING STATES

Aug. 17–18: Council and Board of Directors Meeting, American Society of Anesthesiologists, Chicago.

Sept. 26–29: "The Metabolic Basis of Heart Disease," American College of Physicians, Wayne State University School of Medicine, Detroit, Mich.

Oct. 12–18: Annual Otolaryngologic Assembly of 1968, Illinois Eye and Ear Infirmary at the Medical Center, Chicago, Ill.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

1968 OTHERS

June 30–July 12: Physicians Institute on Medical Aspects of Alcoholism, Rutgers—The State University, New Brunswick, N.J.

June 30–July 6: Third International Seminar and Exhibition on World Problems in Rehabilitation of the Disabled, Conference Centre, Hotel Metropole, Brighton, England.

July 8–11: Postgraduate course: Ophthalmology, University of Colorado School of Medicine, Stanley Hotel, Estes Park, Colo.

July 15–18: Third annual conference on The Changing Role of the Medical Record Librarian, University of Colorado School of Medicine, The Stanley Hotel, Estes Park, Colo.

Aug. 1–3: Postgraduate course in Dermatology, University of Colorado School of Medicine, Aspen, Colo.

Aug. 5–8: Postgraduate course in Pediatrics, University of Colorado School of Medicine, Aspen, Colo.

Sept. 7–11: Second International Congress of the Transplantation Society, Americana Hotel, New York City.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo.

Sept. 28–Oct. 3: Western Hemisphere Congress, International College of Surgeons, Honolulu, Hawaii.

Oct. 6–11: XVI Biennial International Congress, International College of Surgeons, Tokyo, Japan.

Oct. 9–11: 15th Western Cardiac Conference, University of Colorado Medical Center, Denver, and Colorado Heart Association.

Oct. 15–18: 51st Annual Meeting, American Dietetic Association, San Francisco, Calif.

Oct. 16–26: Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, International College of Surgeons.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

Oct. 26–Nov. 11: Around-the-World Postgraduate Clinics, International College of Surgeons, India, Egypt, Holy Land, Israel, and Greece.

Nov. 11–14: Interstate Postgraduate Medical Association Assembly, Pittsburgh, Pa.

Nov. 13–16: Forty-seventh annual convention, National Easter Seal Society for Crippled Children and Adults, Sheraton-Boston Hotel, Boston, Mass.

Nov. 19–20: 22nd Annual Meeting, American Heart Association Council on Arteriosclerosis, Bal Harbour, Fla.

Nov. 20–22: Sixtieth annual conference, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Nov. 21–24: 41st Scientific Sessions, American Heart Association, Bal Harbour, Fla.

Nov. 22–23: Psychedelic Drugs meeting, The Hahnemann Medical College and Hospital of Philadelphia, Pa.

Nov. 25–26: Annual Assembly Meeting, American Heart Association, Bal Harbour, Fla.

Nov. 25–26: Meeting, American Society of Nephrology, Shoreham Hotel, Washington, D.C.

1969 NEIGHBORING STATES

Apr. 30–May 4: M.A.C. VI-Midwest Anesthesiology Conference, Illinois Society of Anesthesiologists, Palmer House, Chicago.

1969 OTHERS

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Exercise and Heart Disease, Workshop

The University of Wisconsin Medical Center and the University Extension in conjunction with the Department of Physical Education—Men will present a two and one-half day workshop entitled "Exercise as a Therapeutic Tool in Coronary Heart Disease," August 22–24. This participation workshop is designed to give the physician personal experience in graded exercise programs, testing procedures, exercise evaluation, and recreational physical activity.

During the mornings of August 22, 23, and 24, guest faculty with national reputations will discuss the theory and physiology of physical activity as well as exercise as a therapeutic tool in coronary artery disease. The guest faculty will include Robert A. Bruce, M.D., Samuel M. Fox III, M.D., John P. Naughton, M.D., Loren H. Parmley, M.D., and others. The University of Wisconsin faculty will include Bruno Balke, M.D. and Charles W. Crumpton, M.D. and others.

The unique aspect of the conference will be the laboratory experience. Physical activity in moderation will be demonstrated to and evaluated by the conference registrants and by exercise physiologists who have experience with varied populations. Both land based and aquatic activity will be used for demonstration of activity and of testing procedures.

For further information contact Thomas C. Meyer, M.D., Department of Postgraduate Medicine, Room 302, 333 N. Randall Avenue, Madison, Wis. 53706.

Conference on the Medical Aspects of Sports

The Tenth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Miami Beach, Fla., at the Hotel Deauville on Dec. 1. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

As was true of the previous nine conferences, the tenth will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums on the management of knee injuries, back problems, and problems

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MEDICAL MEETINGS *continued*

related to vision in sports. Other sessions will be devoted to a series of clinical concerns in sports warranting increased attention (eg, cauliflower ear, pulled muscles, facial injuries, and communicable disease). One discussion session will be devoted to the controversial issues affecting participation of young athletes, another to health and safety considerations in the conduct of aquatic activities.

The featured luncheon speaker will be Payton Jordan, head coach of the 1968 U. S. Olympic track and field team, who will discuss "The Olympics in Retrospect."

The Conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

Laryngology and Bronchoesophagology Course

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, will conduct a postgraduate course in Laryngology and Bronchoesophagology from Sept. 23 through Oct. 4. This course is limited to 15 physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants are to write directly to the Department of Otolaryngology, College of Medicine, University of Illinois at the Medical Center, Postoffice Box 6998, Chicago, Ill. 60680.

Congress on Diseases of the Chest

The Tenth International Congress on Diseases of the Chest sponsored by the Council on International Affairs of the American College of Chest Physicians will be held at the Washington Hilton Hotel, Washington, D.C., Oct. 4–8. It is anticipated that more than 2,000 physicians from throughout the world will attend.

One hundred forty-four scientific papers on all aspects of cardiovascular and pulmonary diseases will be presented. Some of the highlights are symposiums on:

Revascularization of the Myocardium. Drs. D. B. Effler, USA; C. W. Lillehei, USA; A. J. Malm, Sweden; and F. M. Sones, USA.

Cardiovascular Surgery. Drs. M. E. DeBakey, USA; C. A. Hufnagel, USA; A. Kantrowitz, USA; M. J. Levy, Israel; S. Miyamoto, Japan; B. V. Petrovsky, USSR; A. Senning, Switzerland; P. G. Uglov, USSR; and R. Zenker, Germany.

Clinical Aspects of Myocardial Infarction. Drs. R. J. Bing, USA; I. Chavez, Mexico; E. Corday, USA; H. Knipping, Germany; and I. S. Wright, USA.

Emphysema and Chronic Bronchitis. Drs. Brian B. Blades, USA; W. H. Herzog, Switzerland; T. Nakamura, Japan; A. A. Sami, Egypt; W. H. Stewart, USA; and W. T. Ulmer, Germany.

Public Health Aspects of Tuberculosis. Dr. D. G. Alarcon, Mexico, moderator.

Sarcoidosis. Dr. L. E. Siltzbach, USA, moderator.

Aerospace Medicine. Dr. C. E. Berry, USA, moderator.

Air Travel and the Cardiorespiratory System. Lt. Gen. K. Pletcher, Surgeon General, U.S. Air Force, and Dr. Peter Siegel, USA, moderators.

Cine–Angiographic Technics in Cardiovascular Disease. Dr. F. M. Sones, USA, moderator.

For further information and registration forms, write the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611, USA.

Montana Medical, Vacation Program

The Cascade County Medical Society has arranged a summer meeting and family entertainment program, called the Big Sky Medical Pow Wow, at Great Falls, Mont., Aug. 15–17. A high quality program with internationally known speakers includes a sports injury program and a lecture by Dr. Milton Helpern on "The Role of the Forensic Pathologist in the Administration of Justice." Entertainment includes a skating exhibition featuring John Mischa Petkevich, U.S. Olympic skater, and the annual East–West Montana All-State football game with proceeds going to the Shriners Hospital for Crippled Children in Spokane, Wash.

The AAGP has approved 11½ hours prescribed credit. Registration fee: $10.

For further information contact R. E. Wynia, M.D., 203 20th Street South, Great Falls, Mont. 59401.

Maternal and Child Health Program

The Division of Maternal and Child Health of the University of California School of Public Health at Berkeley announces the following postgraduate programs for pediatricians, obstetricians, and other physicians interested in receiving training in the field of Maternal and Child Health. These programs all lead to the degree of Master of Public Health. Tax-exempt fellowship support is available.

Maternal and Child Health. A 9-month program in planning, organizing, and operating comprehensive health services for mothers and children.

Family Planning. A 9-month academic program providing intensive work in family planning as part of the general graduate preparation of maternal and child health specialists.

School Health. A 9-month academic program providing intensive work in school health as part of the general graduate preparation of maternal and child health specialists.

The Multiple Handicapped and Mentally Retarded Child. A 21-month academic and clinical program in planning, organizing, and operating community services for children with multiple handicaps, including mental retardation. This program is primarily for Board-certified or Board-eligible pediatricians, or for physicians on the staff of institutions for the mentally retarded or handicapped children.

Career Development Programs. Three-year academic and residency programs consisting of one year of academic training leading to the degree of Master of Public Health combined with residency training in Pediatrics or Obstetrics-Gynecology. The training emphasizes planning, organization, and operation of comprehensive health programs.

Applications are now being accepted for the group entering in July or September 1969. For information write to Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, Calif. 94720.

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Medical Assistants' Charter Becomes Part of Medical Society Exhibits

The Charter of the Wisconsin State Medical Assistants Society and a roll of charter members penned in gold have now been hung in appropriate display at the State Medical Society building in Madison.

In formal ceremony April 21, Society president, Dr. Harold J. Kief of Fond du Lac, accepted the charter from Miss Donna Schultz, president of the Wisconsin State Medical Assistants Society. The ceremony was part of an executive board meeting of the WSMAS held at the State Medical Society headquarters. Charter members present for the occasion were Mrs. Lucille Skolaski, Miss Alice Roelse, Miss Edith Murphy, Mrs. Dolores Mitka, and Miss Alice Budny.

DR. HAROLD J. KIEF, president of the State Medical Society of Wisconsin accepts the Charter and Roll of Charter Members of the Wisconsin State Medical Assistants Society from the president, Miss Donna Schultz (left) while Miss Alice Budny, state representative to the American Association of Medical Assistants which granted the Charter, looks on.

CHARTER MEMBERS of the Wisconsin State Medical Assistants Society present for the presentation of the Charter and Roll of Charter Members to the State Medical Society of Wisconsin April 21 are shown above with one of the WSMAS's advisors, Dr. Raymond M. Baldwin of Beloit. They are: Miss Edith Murphy, Miss Alice Budny, Mrs. Dolores Mitka, Miss Alice Roelse, and Mrs. Lucille Skolaski.

In accepting the charter Doctor Kief urged the medical assistants "to continue your enthusiastic establishment of seminars in psychology, communications, bookkeeping, legislation and continue your influence which helped create vocational schools throughout the state."

Houghton Student Loan Fund Grows

The John H. Houghton, M.D. Medical Student Award fund reached $4,149.50 at the end of April. The fund was established in early March by Dr. John H. Houghton who died March 25. The fund will be used for honoring outstanding medical students from Wisconsin medical schools who show promise of becoming a "complete physician," an achievement Doctor Houghton stressed consistently in his activities with organized medicine and particularly while president of the State Medical Society.

The first such award is being presented this May at the annual meeting of the State Medical Society in Milwaukee. Contributions to this fund are being administered by the State Medical Society's CES Foundation.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MAY 1968

1 Madison Area Radiologists
3 Program Planning Committee, State Advisory Committee on Alcoholism
3 Wisconsin Association on Alcoholism
6 Division on Clinical Oncology, University Hospitals
7 Board of Trustees, Dane County Medical Society
7 Madison Anesthesiology Society
7 Madison Urology Society
10 Madison Society of OB–GYN
11 Executive Committee, SMS Council (Milwaukee)
12 SMS Council (Milwaukee)
13 SMS Annual Meeting (Milwaukee)
14 SMS Annual Meeting (Milwaukee)
15 SMS Annual Meeting (Milwaukee)
16 SMS Annual Meeting (Milwaukee)
20 Madison Academy of Internal Medicine
20 Insurance Advisory Committee, Dane County Medical Society
23 Quarter Century Alumni, University of Wisconsin Medical School
25 Maternal Mortality Study Committee of SMS Division on Maternal and Child Welfare (Milwaukee)
27 Dane County Woman's Auxiliary Benefit
28 Dept. of Surgery, Univ. Hosp.
29 Ad Hoc Committee on Medical Practice Act

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics, with the location in parentheses.

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Madison Physicians Attend Symposium

Drs. Gordon Garnett, William B. Hobbins, and Yong Ho Park, Madison, recently attended the 19th Hahnemann Symposium on "Pre- and Postoperative Management of the Cardiopulmonary Patient" in Philadelphia.

Dr. Morgan Resigns as Health Commissioner

Dr. S. F. Morgan, health commissioner of Whitefish Bay for 24 years, recently resigned his post to enter private practice. He will be succeeded by *Dr. Thomas J. Cox,* Milwaukee.

Dr. McLane Guest Speaker

Dr. Hugh J. McLane, Fond du Lac, recently spoke before the members of the Evans school PTA. He appeared on behalf of the Wisconsin Heart Association and presented information on "How to Save Your Neighbor's Life and Your Own."

Dr. Aprahamian Joins Clinic

Dr. Charles Aprahamian, Milwaukee, will join the staff of the Krohn Clinic, Black River Falls, in July. He graduated from the Marquette University School of Medicine in 1962 and has been serving his internship and surgical residency since his graduation. Doctor Aprahamian is a Board Certified surgeon.

Dr. Mudge Guest Speaker

Dr. William A. Mudge, Kenosha, recently was the guest speaker of the second session of a series of five sessions that is being held on the theme of Sex Education at the First Methodist Church, Kenosha. Doctor Mudge's topic was entitled "The Anatomy of Sex."

New Staff Members at Tomah VA Hospital

Drs. Josephine Schmitt and Metodio Reyes recently were added to the medical staff of the Tomah VA Hospital. Doctor Schmitt is a graduate of the Marquette University School of Medicine and has been associated with the VA Hospital at Downey, Ill. Doctor Reyes, a native of the Philippines, earned his medical degree from the University of Santo Tomas and has been a member of the staff of the Illinois State Hospital.

Dr. Hoggatt Named to Fellowship

Dr. John E. Hoggatt, Neenah, recently was elected to a fellowship in the American Academy of Pediatrics. Certification requires a minimum of five years post-medical school experience.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Balistrieri Guest Speaker

Dr. J. J. Balistrieri, Milwaukee, recently was the guest speaker at the Watertown Memorial Hospital Auxiliary's "Florence Nightingale Luncheon." Doctor Balistrieri is the director of Adolescence Psychiatric In-Patient Service at the Milwaukee County Hospital.

Dr. Janes Joins Clinic

Dr. Donald R. Janes, Wausau, recently joined the Wausau Clinic. Doctor Janes graduated from the University of Kansas Medical School in 1960 and completed his internship at the University of Kansas Hospitals. He served a residency in general surgery at St. Luke's Hospital in Kansas City, Mo., and spent two years as a general surgeon with the United States Air Force at Amarillo Air Force Base, Tex. From July 1964 until April 1968, he completed his residency in obstetrics and gynecology at Mayo Clinic, Rochester, Minn., and during this period he spent six months at Cook County Hospital in Chicago, Ill.

Dr. Sargeant Joins Bachhuber Clinic

Dr. James Sargeant, Mayville, will join the staff of the Bachhuber Clinic in July. He graduated from the Marquette University School of Medicine and is completing his internship at St. Joseph's Hospital, Milwaukee. Doctor Sargeant is the son of *Dr. George M. Sargeant,* Baldwin physician, who had practiced in that area for 25 years before his retirement in 1960.

Doctor Sargeant will practice at the Clinic during the leave of absence which *Dr. Michael Bachhuber* will take as of July. Doctor Bachhuber plans to study pediatrics at Milwaukee Children's Hospital, but he and his family will maintain residence in Mayville.

Drs. Carter and Fauerbach Honored

Drs. Homer Carter and *Louis Fauerbach,* Madison, recently were honored at a banquet by the Madison Area Chapter of the Wisconsin Academy of General Practice. Doctor Fauerbach is a charter member of the chapter and worked in the Madison Health Department for 40 years. Doctor Carter has practiced for more than 50 years and is a past president of the Dane County Medical Society. He was chief-of-staff at Madison General Hospital and first secretary of the medical staff at St. Mary's Hospital, Madison.

Dr. Maas Honored by Community

Dr. David Maas, Webster, recently was honored at an Appreciation Day Smorgasbord by the people of Webster. Doctor Maas served the community for many years and has moved to Bozeman, Mont.

Dr. Welsch Guest Speaker

Dr. Raymond G. Welsch, Kenosha, recently was the guest speaker at the Kenosha League of Women Voters annual meeting. The League has been doing research on the public health services available in the city and county, and Doctor Welsch, member of the City of Kenosha public health board, explained the proposed change, made possible by Wisconsin legislative action in 1961.

Dr. Calloway Introduces Book

Dr. N. O. Calloway, former chief of medicine at the Veterans Administration Hospital, Tomah, from 1963–66, recently had the medical handbook entitled "Databook on Aging and Senescence" introduced at the 25th anniversary meeting of the American Geriatric Society held in New Orleans.

Doctor Calloway came to Madison two years ago and has done much of the work on the book here because of the library and research facilities at the University of Wisconsin. He graduated from the University of Illinois School of Medicine in 1943 and taught chemistry at Tuskegee Institute and Fisk University, pharmacology at the University of Chicago. He was an assistant professor of medicine at the University of Illinois from 1946 to 1958 and maintains a private practice.

Dr. Sautter Guest Speaker

Dr. Richard D. Sautter, Marshfield, recently was one of the guest speakers at the third annual Cardiac Symposium sponsored by the Kansas City, Mo., Heart Association. Doctor Sautter spoke on urokinase, an enzyme found in human urine. The Marshfield Clinic, which Doctor Sautter is affiliated with, is one of a dozen selected institutions engaged in a two-year study of urokinase under auspices of the National Heart Institute.

Dr. Parsons Answers JAMA Question

Dr. William B. Parsons, Jr. of Madison supplied the answer to a question in the Q & A feature of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION in its April 8 issue. The question concerned "Diarrhea Associated with Thyroid Medication."

Dr. Pois Guest Speaker

Dr. Allan J. Pois, of the department of cardiovascular surgery at the Jackson Clinic, Madison, recently spoke at a meeting of the Madison Kiwanis. He spoke on "Heart Transplants—Present Status and Future Development."

Dr. Parsons Guest Speaker

Dr. William B. Parsons, Jr., Jackson Clinic, Madison, recently spoke at a meeting of the Madison Gyro Club. His talk was on "Coronary Risk Factors and the Coronary Drug Project."

Dr. Tenney Guest Speaker

Dr. H. Kent Tenney, emeritus clinical professor of pediatrics at the University of Wisconsin, recently spoke to the members of the Racine Branch of the American Association of University Women. He spoke on "Preventive Aspect of Emotional Deprivation." Doctor Tenney is the author of an informal book on child care, "Let's Talk About Your Baby," and is a frequent speaker on the emotional and physical well being of children. Presently he is the director of a health education program, "March of Medicine," which is broadcast weekly over approximately 50 Wisconsin radio stations and sponsored by the State Medical Society of Wisconsin.

Dr. Winters Chosen Consultant

Dr. Kenneth J. Winters, pediatrician with the Wauwatosa Clinic, recently was chosen as one of the physician consultants of the American Academy of Pediatrics to evaluate the medical aspects of Head Start programs in nearly 2,000 communities throughout the United States.

Rotary Club Honors Dr. Falk

Dr. V. S. Falk, Edgerton, medical editor of the WISCONSIN MEDICAL JOURNAL, recently was honored by the Edgerton Rotary Club as the 1968 Honored Citizen of the Edgerton community. Doctor Falk graduated from the University of Wisconsin Medical School in 1939 and served with the Marines in World War II. He has been the Edgerton health officer since 1959, and is chief-of-staff of Memorial Community Hospital and on the medical staff of the Mercy Hospital, Janesville.

Dr. Anthony R. Curreri, chairman of the department of surgery at the University of Wisconsin Medical School told of his association with Doctor Falk in Vietnam and the conditions under which they worked. Doctor Falk returned last January from his second two-month tour of volunteer duty in Vietnamese civilian hospitals.

Dr. McKenna Joins Clinic

Dr. David H. McKenna, Wheaton, Md., recently became associated with the Beaumont Clinic, Green Bay. Doctor McKenna graduated from the St. Louis University School of Medicine, St. Louis, Mo., and interned at St. Louis City Hospital. His residency was served at the St. Louis V. A. Hospital and from 1963–1966 he was a research fellow and assistant professor of medicine in the Cardiovascular Research Laboratory, Department of Medicine, University of Wisconsin, Madison. Doctor McKenna served as a captain with the United States Army Medical Corps before joining the Clinic.

Dr. Alvarez Guest Speaker

Dr. Ubaldo Alvarez, La Crosse, recently was the guest speaker at a meeting of the St. Francis Alumnae Association held in St. Francis School of Nursing.

Dr. Shealy Writes Book

Dr. C. Norman Shealy, chief of the neurosurgical staff at Gundersen Clinic and La Crosse Lutheran Hospital, has written a book on spinal injections. The book, "Spinal Acuology," is the outgrowth of an article he wrote titled, "The Dangers of Spinal Injections Without Proper Diagnosis," which was published in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION in September 1966. Doctor Shealy joined the Clinic in September 1966 and is also a clinical assistant professor in the department of neurosurgery at the University of Wisconsin.

Dr. Wagner Guest Speaker

Dr. Harold B. Wagner, Kenosha, recently was the guest speaker before the Kenosha B'nai B'rith Lodge. He spoke on "The Role of the Pathologist in Medicine." Doctor Wagner, a forensic pathologist, served 12 years as coroner's pathologist in Chicago and is presently chief clinical pathologist at St. Catherine's Hospital and is a consultant to the Wisconsin State Crime Laboratory. He is also a fellow of the American Academy of Forensic Sciences.

Doctors Return to Jackson Clinic

Drs. David G. Bryant, William J. McAweeney, and *Blake E. Waterhouse* recently returned to the Jackson Clinic, Madison, after serving as captains in the United States Army Medical Corps for two years. Doctor Bryant also served a tour of duty in Vietnam.

Doctor Bryant served at Ft. Carson U. S. Army Hospital, Colo., and a tour in Vietnam at the 45th M. U. S. T. Surgical Hospital at Tay Ninh. A graduate of New York Medical College, Doctor Bryant interned for a year at St. Luke's Hospital in Cleveland and served a three-year residency in orthopedic surgery at University Hospitals, Madison. He has returned to the Clinic in the department of orthopedic surgery.

Doctor McAweeney served at U. S. Army Hospital, Ft. Jackson, Columbia, S. C. He graduated from George Washington University School of Medicine, Washington, D.C., and interned at St. Vincent Hospital, Worcester, Mass. He served a residency in medicine at St. Vincent Hospital and at Lemuel Shattuck Hospital, Boston. Doctor McAweeney has returned to the Clinic in the department of internal medicine.

Doctor Waterhouse served at Darnall Army Hospital at Fort Hood, Tex. He received the Army Commendation Medal for Meritorious Service at Fort Hood during the period, March 1966 to March 1968. A graduate of the Indiana University School of Medicine, he interned at Iowa Methodist Hospital, Des Moines, and served a three-year fellowship in medicine at the Mayo Clinic, Rochester, Minn. He has returned to the department of internal medicine at the Clinic. Doctor Waterhouse is a diplomate of the American Board of Internal Medicine.

Dr. Pitot Given Parke–Davis Award

DR. HENRY C. PITOT (center), a professor of oncology and pathology at the University of Wisconsin, receives the annual Parke, Davis & Company pathology award from Dr. Arthur C. Upton (left) of the American Society of Experimental Pathology. Looking on is Dr. D. H. Kaump of Parke–Davis' Ann Arbor, Mich., research laboratories. The drug firm sponsors the award which recognizes outstanding contributions to the conquest of disease. He was awarded $1,000, a bronze medal, and travel expenses to the 1968 annual meeting of the American Society for Experimental Pathology held in Atlantic City in April. The Society administers the award for Parke–Davis.

Dr. Lokvam Speaks to Medical Assistants

Dr. Leif H. Lokvam, Kenosha, was honored guest and speaker at the March meeting of the Kenosha County Medical Assistants. Doctor Lokvam returned last fall from Saigon where he served as a volunteer physician in a civilian hospital under the AMA program of "Volunteer Physicians for Viet Nam." He described some of his experiences in Saigon and showed slides of the area.

UW Alumni Awards Announced

The University of Wisconsin Alumni Association honored six prominent graduates with the Distinguished Service Award at the annual dinner May 11. Two of the honorees are physicians. They are:

Dr. Anthony R. Curreri, professor and chairman of surgery at the Medical School, who has taught at the University of Wisconsin since 1939. A 1933 graduate, he is a surgical consultant to the Surgeon General of the Army and has served on the National Advisory Cancer Council of the Public Health Service.

Dr. Karl H. Beyer, Jr., a Kentucky native, who is senior vice-president for research at Merck, Sharp, and Dohme Research Laboratories, West Point, Pa. A 1943 graduate, he serves on a special board of the Food and Drug Administration to review drug product and advertising claims.

Dr. Wagner Addresses Kenosha Group

Dr. Harold B. Wagner, pathologist at St. Catherine's Hospital in Kenosha, addressed mem-

bers of the Kenosha County Medical Assistants group in April. Doctor Wagner gave a resumé of the history of pathology and his views of the medical assistant's duties in an electronic and computer age.

Dr. Meyer Fox President Chicago Group

Dr. Meyer S. Fox of Milwaukee has been elected president of the Chicago Laryngological and Otological Society. This society was founded in 1899 "to promote the science and art of medicine particularly as it applies to the field of otolaryngology."

Doctor Fox is a practicing otologist who has been interested and actively engaged as a consultant to industry in the problems associated with occupational hearing loss. He is the author of numerous papers dealing with the industrial noise problem.

Doctor Fox is an associate professor, Department of Otolaryngology, Marquette School of Medicine, and is a member of the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology. For several years he has been chairman of the Division on Ear, Nose, and Throat of the Commission on State Departments of the State Medical Society of Wisconsin.

Dr. Stewart Explains New Artificial Kidney

Another step in the development of a new type of artificial kidney was reported in April in Philadelphia at meetings of the American Society for Artificial Internal Organs by Dr. Richard D. Stewart of Marquette School of Medicine, Milwaukee.

This newest of artificial organs is called the "capillary kidney" because it simulates the human kidney's vascular capillary network in that it is made of hollow, hair-size, cellulose fibers. The fibers, approximately 11,000 of them, are packed into a compact case about the size of a flashlight. The design is an innovation in organ support systems which holds great promise as a dialyzing device.

The capillary kidney, also called the hollow fiber kidney, is being developed by the Dow Chemical Company, Walnut Creek, Calif. Part of the testing is being done in Milwaukee by Doctor Stewart, a former Dow scientist, and the originator of the research on the capillary kidney.

The kidney studies have been supported under a contract from the National Institute of Arthritis and Metabolic Diseases, N.I.H., Bethesda, Md.

Dr. Kalambeheti Joins Clinic

Dr. Kitti Kalambeheti, Mullens, W. Va., will join the Sparta Clinic in July. Doctor Kalambeheti is a native of Thailand and is a graduate of the University of Medical Sciences, Bangkok. He is a board-qualified surgical specialist, and his postgraduate training included four years residency in surgery and six months in orthopedics. He has been in private practice with a multi-specialty group in West Virginia.

NEW WORKMEN'S COMPENSATION RULES

The 1967 session of the Wisconsin state Legislature passed amendments to the state's Workmen's Compensation Act which affect you in your capacity as an employer. These new rules include the following:

1. As an employer, you will be subject to the Workmen's Compensation Act even though you employ less than three persons if you pay wages of $500 or more in any calendar quarter (this works out to $166.67 a month). This portion of the law goes into effect July 1, 1968, but the employer is not subject to the Aet until the first day of the calendar year succeeding the quarter in which he pays wages in excess of the statutory amount. This means that coverage for most offices with less than three employees will begin Jan. 1, 1969.
2. Your payment of wages to an employee during a period of disability or absence from work to obtain treatment will be deemed the payment of compensation under the Act if you knew of the employee's condition and its alleged relation to his employment.

In addition, the new law provides that verified reports by dentists are to be accepted as evidence of their diagnosis and determination of necessity for treatment for conditions which they are called upon to treat. They may not, however, be accepted as evidence of disability, as a physician's report may be.

We refer you also to the detailed article, *What Every Doctor Should Know About Workmen's Compensation*, which appeared at page 20 in the January 1968 issue of the WISCONSIN MEDICAL JOURNAL.

MANITOWOC

Dr. Hammond Honored for 70 Years Service

When a physician can look back on 50 years of medical practice, that is a major goal in his career, but when a physician can reflect on 70 years of practice, that is extraordinary and almost unheard of today. However, *Dr. Frederick W. Hammond* of Manitowoc on April 6, began his 71st year as a licensed practitioner of medicine in the state of Wisconsin.

In recognition of his long contribution to the practice of medicine in Manitowoc County and the state of Wisconsin, the Manitowoc County Medical Society honored him at a dinner April 25 at Sorge's Charcoal House in Manitowoc. A resolution recognizing Doctor Hammond's contribution and conveying the best wishes of the MCMS for his continued health was unanimously adopted at the Society's last meeting. The resolution stated, in part: "This physician has always conducted himself according to the ethics of his profession; and . . . Our community has greatly benefited because he has long been an integral part of it; and . . . He has been an inspiration to many of the young men entering our profession; . . ."

The State Medical Society of Wisconsin also recognized Doctor Hammond's service by presenting him with a frosted black glass plaque in which the Society seal was embedded in gold overlay and surrounded by the inscription: F. W. Hammond, M.D., Seventy Years Service, April 1968.

Doctor Hammond was born March 17, 1873, on a farm in the town of Cato. He graduated from the Milwaukee Medical College in 1898 and began practice in that year in Wyocena. He practiced there until 1914 when he moved to Manitowoc where he has resided to the present time. He retired from active practice in 1961.

Doctor Hammond joined the State Medical Society's "Fifty-Year Club" in 1951. He had become a life member in 1949. He was named Manitowoc's outstanding citizen in 1948, the same year in which the Manitowoc County Medical Society gave him a testimonial dinner in recognition of his 50 years of practice, 34 of them in Manitowoc.

Physicians whose names appear in italics are members of the State Medical Society.

WINNEBAGO

Tour Nursing Home at Winnebago

Members of the Winnebago County Medical Society and their wives toured the Pleasant Acres Skilled Nursing Home May 2 near Winnebago. Following the tour the group had dinner in the Home's dining room and then heard a short panel discussion by Winnebago County Institutions staff members including Dr. Thomas Kelley, psychiatrist, who spoke in the area of geriatric psychiatry. Plans for the evening were coordinated by *Dr. R. William Roberts*, program chairman for the Society, and Dr.

A HEARTY HANDSHAKE FOR A HEARTY GENTLEMAN was in order for 95-year-old *Dr. Frederick W. Hammond* of Manitowoc when he was honored April 25 by the Manitowoc County Medical Society for 70 years of medical practice. Extending the good wishes are *Dr. R. W. Hammond*, a son, and *Dr. Theodore A. Teitgen*, son of a former associate, Dr. Arthur Teitgen, both of Manitowoc; Mr. Howard Brower, Madison, associate secretary of the State Medical Society. Doctor Hammond; *Dr. William D. James*, Oconomowoc, president-elect of the State Medical Society; and *Dr. William C. Rondolph*, president of the Manitowoc County Medical Society.

R. H. Ritter, medical director of Winnebago County Institutions.

The Winnebago County Medical Society is participating in sponsoring the visit of the State Division of Health Mobile Survey Unit from April 29 through July 12. *Dr. E. N. Wright*, president of the Society, has publicly urged all persons who are aware that they have high blood pressure or diabetes to take these tests.

MARATHON

Emergency Aid Classes Held

The Marathon County Medical Society in cooperation with the Marathon County Safety Council conducted classes in May on "Emergency Aid for the Critically Ill and Injured." The project is an outgrowth of the conservation of life and property committee of the Wausau Area Chamber of Commerce. Dr. Bruce Gargas assisted with the planning. The first class was conducted by *Dr. W. G. Locher* who outlined acute respiratory emergencies and resuscitation methods. The second class was conducted by *Dr. Thomas O. Miller*. He spoke on types of fractures and the dangers involved in handling and transporting victims.

The series was open to police and fire personnel and members of the Safety Council. Plans call for a resumption of classes in September with the possibility of increasing its availability to other groups in the area.

MILWAUKEE

National Blue Shield Honors Surgical Care

SURGICAL CARE of Milwaukee received honors for its 25 years of participation in the National Association of Blue Shield Plans at the annual business meeting of the NABSP in San Francisco in April. National president John W. Castellucci (left) congratulates Dr. George E. Collentine, Jr., president of the board of Surgical Care, the Blue Shield Plan of The Medical Society of Milwaukee County. Looking on are James O. Kelley, executive secretary and general manager who recently celebrated his 30th anniversary with the Society, and Thomas Girard of Surgical Care. (Photo courtesy WHITEFISH BAY HERALD)

WASHINGTON

Sponsors Family Life Education Program

A public meeting to discuss family life education was held in April at the West Bend high school gym through auspices of the Washington County Medical Society as a community service. Capt. James P. Semmens of the U. S. Navy Medical Corps, a well known and nationally recognized authority on this subject, was the speaker. The appearance of Capt. Semmens is part of a continuing program of involving parental, church, and professional groups in developing family life education.

Capt. Semmens, chief of obstetrics and gynecology, U. S. Naval Hospital, Oakland, Calif., is a graduate of Marquette University School of Medicine and was in general practice in Waupun for several years.

CHIPPEWA

Dr. Hardacre, Marshfield, Speaker

Dr. Jerry M. Hardacre of the Marshfield Clinic spoke to the members of the Chippewa County Medical Society May 7 in Chippewa Falls. His subject was "Surgery for the Ulcer Patient."

WAUKESHA

Announce Availability of Scholarships

The Waukesha County Medical Society has announced the availability of additional "SOS" scholarships to students who presently reside in Waukesha County. The "SOS" scholarship was established in 1964 from funds derived from the "Sabin Oral Sunday" drive.

CALUMET

Help With Tuberculin Skin Test

The Calumet County Medical Society in April cooperated with the Wisconsin Anti-Tuberculosis Association and the Calumet County public health nurse in offering tuberculin skin tests to all first and ninth grade students enrolled in Calumet County schools.

DOUGLAS

Tour Parkland Hospital

Dr. and Mrs. *Oscar Farias* entertained members of the Douglas County Medical Society and its Woman's Auxiliary at a dinner Apr. 3 in Parkland Hospital. Following the dinner, guests toured the hospital to view facilities.

* * *

THE BI-MONTHLY medical magazine, *"Ca—A Cancer Journal for Clinicians,"* is sent to physicians and medical students by the American Cancer Society. Doctors: to receive this journal, contact your local ACS office.

SECTION OPHTHALMOLOGY

JUNE 1968 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

DIAGNOSTIC OCCLUSION IN STRABISMUS

OTTO A. WIEGMANN, M.D., Brookfield, Wis.

Monocular diagnostic occlusion as a method to reveal latent amounts of deviations in exotropias and hypertropias has become controversial in the last years. Several authors found that many exodeviations became smaller under prolonged occlusion of up to several weeks and months, contradicting earlier investigations on large numbers of exotropia and hypertropic patients which showed consistent increases after occlusion.

More recently, short-term occlusion has been advocated (for 30 minutes to 1 hour) not only to reveal latent deviations in exo- and hypertropias but also to finally reclassify exotropias according to their relation of near-to-distance deviation. Particularly, cases of "divergence-excess" exotropia (distance deviation greater than near deviation) were recommended for monocular occlusion after which frequently the near deviation became equal to ("basic exotropia") or exceeded the distance deviation ("convergence-insufficiency" exotropia). Actual data on short-term occlusion, however, were never submitted.

Therefore, a study was done on 84 patients with different types of exotropia. The occlusion time was limited to two hours during which near and distance deviations were measured with the prism cover test at regular intervals. Fusion was not resumed at any time. The majority (70%) of patients showed an increase of deviation within one hour, particularly those with a divergence excess type of exotropia where mainly an increase of the near deviation occurred (51%). The highest number of patients with "no change" after occlusion (38%) were found in the group of convergence insufficiency exotropias.

If changes in deviations of 20% and higher were considered "significant," one third of the "divergence-excess" type patients had to be reclassified as "basic exotropias." In primarily "basic" and "convergence-insufficiency" exotropias reclassification into a different group was necessary in about 27% and 9% respectively. At the same time 38 cases (44%) either developed a hypertropia or showed an increase in an existing hypertropia when 2 prism diopters were considered a significant change.

The results suggest that short-term occlusion may be helpful to avoid surgical undercorrections (the most frequent failure), to select surgery according to the newly established type of exotropia, and to recognize latent amounts of hypertropia. The question whether those cases which did not show any change in deviation should be subjected to longer occlusion still remains open. The final judgment on the usefulness of occlusion can only come from significantly improved surgical results. Further indications for diagnostic occlusion exist in cases of phorias with subjective symptoms where the disruption of fusion may give relief and finally in some cases of high infantile esotropia where a paralysis of the 6th nerve has to be ruled out.

The theoretical interpretation of monocular occlusion is difficult. Though fusional impulses are believed to persist over long periods of time, it is questionable whether long-term occlusion gives more "physiological" results since in cases of monocular blindness in formerly normal patients usually large deviations develop. Short-term occlusion, on the other hand, may not release the "latent deviation" fully since all former investigators found continuously changing deviations (decreasing or increasing) after weeks and months.

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Summary of paper presented at meeting of Milwaukee Ophthalmological Society, Apr. 23, 1968.

Doctor Wiegmann is Assistant Professor, Department of Ophthalmology, Marquette School of Medicine, Milwaukee.

WISCONSIN–UPPER MICHIGAN SOCIETY O–O

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology met May 11 and 12 at Manitowoc. Dr. Rodney J. Sturm, Madison, talked about "Problems of Glaucoma Surgery" and Dr. Peter A. Duehr, Madison, spoke on "Glaucoma Surgery with Aphakia."

A special event for the ladies this year was a tea held by Mrs. Robert C. Randolph of Manitowoc, wife of the Society's president.

MONROE PHYSICIAN ADDRESSES RESIDENTS

Dr. Dwain E. Mings of The Monroe Clinic recently spoke to the University of Wisconsin ophthalmology residents about various surgical techniques.

SPECIALTY SOCIETIES

Wisconsin Academy of General Practice

Another approach by general practitioners to improve their image with medical students and gain more prestige in hospitals was proposed May 13 in Milwaukee at a special meeting of delegates of the Wisconsin Academy of General Practice.

Several Milwaukee hospitals have limited the circumstances in which general practitioners may assist at surgery. Medical students are being attracted to specialty fields rather than to general practice.

Because the American Academy of General Practice recently had its request to establish a board of certification denied by a section of the American Medical Association, a fellowship program, which the Academy could establish and operate itself without control by the AMA, has been suggested as a substitute. This suggestion was to be taken up at the May 25 meeting of the AAGP in Chicago.

Physicians whose names appear in italics are members of the State Medical Society.

Milwaukee Academy of Medicine

"The Pharmaceutical Industry Under the Microscope" was the topic discussed by Dr. Maurice L. Tainter at the 943rd meeting of the Milwaukee Academy of Medicine May 21 at the University Club of Milwaukee. Doctor Tainter is vice-president of Sterling Drug Inc. and vice-chairman of Sterling Research Board.

WISCONSIN'S HEALTH by E. H. JORRIS, M.D., State Health Officer

RADIATION MONITORS READY AND ABLE

More than 5,000 monitors in Wisconsin have been trained and equipped with radiological instruments to give them the capability to measure and report levels of radiation to local and state governments in the event of a nuclear attack.

Information received from these persons would be evaluated by the trained local and state radiological officers and used to supply survival information to the public.

Radiological instruments of several types and ranges are assigned to the monitoring teams at the completion of a sixteen-hour radiological monitor training course. Radiological instruments are also located in each public fallout shelter. The total number of instruments assigned to monitoring teams and fallout shelters in Wisconsin is 22,000.

To insure continual operational readiness of the radiation monitoring instruments, the United States Department of Defense, Office of Civil Defense, requested the states to develop a plan for a federally-funded facility to inspect, repair, and calibrate all radiological instruments located in the state. The State Board of Health, now the Division of Health of the Department of Health and Social Services, submitted a plan which was accepted by the Department of Defense in June 1965, and the facility became fully operational in December 1965.

The annual inspection, repair, and calibration of the 22,000 instruments located in Wisconsin is accomplished by a staff of our electronic technicians and a secretary. Each technician spends about one-half of his time in the field. They travel to each county in the state where a physical inspection is made, batteries are replaced, and the meters checked for electrical operation.

Defective instruments are replaced. The faulty equipment is returned to the service shop for repair and calibration.

Replacement of parts is a common necessity of the repair operation. Parts are kept in a supply inventory at the shop. After each repair, the instruments are calibrated using Cobalt 60 as the source of radiation.

An inventory record of all instruments is made during the on-sight inspection. This record is kept in the office of the maintenance-calibration shop and by the local and county civil defense directors.

* * *

PRESS RELATIONS AND PHYSICIANS

Is it proper for a physician to discuss his patient's medical condition, disease or illness with the press?

According to the AMA Judicial Council's opinion adopted in November 1967, a physician's obligation is to his patient.

However, a patient, by virtue of his position, may have an obligation to others such as stockholders or voters to whom he may be responsible. If such an obligation exists, the disclosure of health knowledge must come from the patient, not the physician. The physician should insure the medical accuracy of any authorized report.

In summary, it is the opinion of the Judicial Council that a physician may not discuss the patient's health condition with the press or the public without the patient's consent or, in the event of his incapacity, the family's consent.

when you want to provide the combined benefits of two accepted agents in the treatment of mild to moderate hypertension. (Contraindications: history of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.)

when you want to prescribe therapy that is generally well tolerated.

(However, adverse reactions may occur. For a complete listing, please refer to the full prescribing information which is summarized below.)

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COMMUNITY HEALTH WEEK: OCT. 20–26

Three timely themes—drug abuse, physical fitness and health careers—are being encouraged for development in local medical society-directed programs marking the sixth annual observance of Community Health Week, October 20–26.

Community Health Week is a public service program inaugurated by the AMA's House of Delegates in 1962.

Goals of the observance are for medical societies, in cooperation with other members of the community health team, to present meaningful programs aimed at furthering public awareness of the wide variety of health services and facilities existing at the community level, to call attention to present health problems and potential solutions, and to call attention to continuing medical advances.

The kit of programming materials for Community Health Week—1968 is now being developed. Materials contained in this comprehensive kit will be built around the three recommended themes.

NEW DIABETES BROCHURE AVAILABLE FOR PHYSICIANS

Although diabetes mellitus may, and frequently does, first appear with the classical "poly" symptoms (polydipsia, polyuria, polyphagia), atypical warning signs may be seen by any of a variety of specialists, according to Arthur Krosnick, M. D., Coordinator of the New Jersey State Department of Health Diabetes Control Program.

A new brochure, *Classification and Management of Diabetes Mellitus*, lists atypical signs of diabetes which might first be seen by any of sixteen specialists—from gynecologist to urologist. "Any physician may find it necessary to diagnose and/or treat diabetes," the brochure points out.

Succeeding pages of the brochure list and explain, according to latest laboratory and clinical criteria, the stages of the disease: prediabetes, latent-chemical, latent, clinical and gestational diabetes. A final section offers general suggestions for management at each stage.

Produced as an educational service of The Upjohn Company, *Classification and Management of Diabetes Mellitus* was written by Dr. Krosnick.

The booklet is available in quantity for hospitals, medical societies or other professional groups, as well as for individual physicians. Requests specifying number of brochures needed should be addressed to: Diabetes Detection Program, 342 Madison Avenue, New York, N. Y. 10017.

* * *

THE 14.8 MILLION veterans of World War II now average 48 years of age, the Veterans Administration reports.

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Jackson Clinic Spring Meeting

The Spring Postgraduate Meeting of the Jackson Clinic and Foundation was held May 29 at the Park Motor Inn in Madison. Program chairmen were *Drs. John H. Morledge* and *William B. Parsons, Jr.* It was supported in part by the Merck Sharp & Dohme Foundation.

Other participants in the program were: *Drs. Luther E. Holmgren*, president of the Jackson Clinic and Foundation; *Gordon A. Tuffli* (pediatrics); *Howard W. Mahaffey* (orthopedic surgery); *Allen J. Pois* (cardiovascular surgery); *Blake E. Waterhouse* and *Carl G. Silverman* (internal medicine); and *Paul A. McLeod* (obstetrics and gynecology).

Dr. Wallace E. Herrell of Northfield, Ill., was guest speaker for the one-day event. Eugene Felker, assistant football coach at the University of Wisconsin, was the evening dinner speaker.

Project Concern Speaker in Madison

Dr. James Turpin, the voice of Project Concern, visited Madison May 15 to assist the Wisconsin group in raising $3,000 for the organization which provides medical care, medical education, and supplementary self-help programs in South Vietnam, Hong Kong, and Mexico. Wisconsin chairman for the fund-raising event, which was a student fair, was Jerry Cherweznik. Wisconsin's goal of $3,000 was part of a national goal of $363,000.

Ileoptomists Group Met

The Ileoptomists, Inc. of Chicago, a non-profit group made up of former patients who have had an ileostomy performed because of ulcerative colitis or multiple polyposis, sponsored a one-day regional meeting of the United Ostomy Association in Chicago at the Ascot Motel on May 4. A number of prominent physicians in the Chicago area participated in the meeting and in workshops devoted to ostomy care. The Ileoptomist group is affiliated with the United Ostomy Association, composed of individuals with ileostomy, colostomy, and ureterostomy. Physicians were urged to direct their patients to the regional meeting for further information regarding ostomy care.

Hemodialysis Center Opened in Milwaukee

State, county and city officials and members of the health professions attended the formal opening of the new Hemodialysis Center at Deaconess Hospital, in Milwaukee May 15.

Deaconess Executive Director Kenneth S. Jamron said the Center is believed to be the largest and most modern in the midwest. The public was invited to the open house.

The Deaconess Hospital Hemodialysis Center has facilities to provide dialysis for nine patients at any one time. The unit includes facilities for training patients and members of their families in home dialysis.

Members of Hemodialysis Center staff demonstrated hemodialysis and had a peritoneal dialysis display during the open house. The center is directed by *Dr. James A. Means.*

Deaconess Hospital began work in the field of the artificial kidney in 1958 under a grant from the John A. Hartford Foundation. Over 800 acute dialyses have been performed at the hospital since that time.

A continuing program of chronic dialysis was begun at Deaconess on Nov. 29, 1966. From that date through May 1, 1968, 741 dialysis procedures were performed.

The Hemodialysis Program at Deaconess Hospital is conducted in cooperation with the Marquette University Department of Continuing Education which assists in training patients and members of their families in home dialysis; and Milwaukee County General Hospital, Milwaukee, and University Hospitals, Madison, where kidney transplants are performed.

La Crosse Hospital in Home Care Program

The Home Care Program at St. Francis Hospital, La Crosse, was planned to provide continuity of patient care from hospital to home. This concept has been developed through a closer relationship between the hospital, physician, and the community nursing agencies and works closely with other paramedical disciplines in discharge planning.

One of the most challenging problems facing today's hospital is to find ways to give adequate care to the ever-growing number of the chronically ill and physically handicapped, many of whom are in need of rehabilitation, the hospital spokesman said.

St. Francis is the fourth hospital in Wisconsin to have a hospital-based referral system.

At St. Francis a Home Care Coordinator acts as a liaison between the hospital and the home health agencies. She coordinates the resources of both in discharge planning to provide continuity of patient care from hospital to home.

It is also planned that patients who return to the hospital for outpatient services within six weeks after discharge would be supervised by the Coordinator.

The central figures in the Home Care Program are the patient and his physician; and their relationship is maintained with care.

Community Nursing Agencies in the city of La Crosse and surrounding counties are prepared to provide professional nursing care on an hourly basis in the home as prescribed by the physician. These

---

Physicians whose names appear in italics are members of the State Medical Society.

agencies provide care in all areas of obstetrics, pediatrics, psychiatry, medical, surgical, orthopedic and geriatric nursing. Their services include direct nursing care such as bathing, irrigations, dressings, catheterizations, injections, blood pressure, urinalysis, and colostomy care. Other services rendered are health promotion and supervision, teaching of the patient and family, and rehabilitation under the direction of a Physical Therapist. These agencies also assist the patient and his family to obtain other needed services such as nutritional counseling, social, welfare, occupational and speech therapy and vocational counseling.

The Home Care Program at St. Francis Hospital was established in October 1966. Sister Mary Ambrose functioned as the coordinator for one year. Mrs. Evelyn Gallagher is the present coordinator. In the 19 months since the program originated, 158 referrals have been made to Home Health Agencies.

Muscular Dystrophy Grant

A renewal grant for $8,500 has been awarded to the Marquette School of Medicine by the Muscular Dystrophy Associations of America, Inc. The grant is the first to be given by MDAA for research on muscular dystrophy in Milwaukee. Announcement of the award by MDAA was in conjunction with its annual fund raising drive which started May 19.

The grant will be used by Robin L. Curtis, Ph.D., associate professor of anatomy, for his continuation studies of a neuromuscular abnormality which is inherited in a breed of mice called the 129 strain.

This is the 10th year that MDAA has supported this project, bringing the total amount awarded to $174,314. Doctor Curtis began his studies when he was affiliated with New Jersey College of Medicine, Jersey City, N.J. He came to Marquette Medical School last summer.

New School of X-ray Technology

A new School of X-ray Technology will be opened this Fall at St. Michael Hospital in Milwaukee. Classes will begin Oct. 1, 1968, according to Sister M. Illumina, administrator.

Faculty will include *Dr. Harold F. Ibach*, chairman, Department of Radiology; *Dr. Lawrence L. Larsen*, radiologist; *Dr. Daniel J. Price*, radiologist; Samuel White, R.T., supervisor, Department of Radiology, and William D. Hess, R.T., director of the school.

After the two-year course, three months of which is spent in intensive classroom instruction at the University of Minnesota, Minneapolis, students are eligible to write the examination of the American Registry of Radiologic Technology. Upon successful completion of the examination a student is certified as a Registered Radiologic Technologist.

Admission requirements to the School of X-ray Technology include graduation from an accredited high school with better-than-average grades, references, and interviews with officials of the school.

Applications are now being accepted. Those requesting admission to the initial class must make written application by Aug. 1, 1968.

The school charges no tuition. Students, however must pay living expenses and incidental fees for books, uniforms, and travel to and from the University of Minnesota, plus university tuition for the three-month period.

St. Michael Hospital will pay students a small stipend to help defray their educational expenses.

Obesity Treatment Program Started

A program which may lead to new insights and means of weight control has begun at Deaconess Hospital, Milwaukee. The first three patients in the Deaconess-TOPS Obesity Treatment and Research Program have been admitted and are now being evaluated, according to Kenneth S. Jamron, executive director.

The research program is being undertaken by Deaconess Hospital under a grant from TOPS Club, Inc., a 250,000-member organization.

All patients admitted to the program will be members of TOPS (Take Off Pounds Sensibly) and will have the permission of their personal physicians.

Applicants have been accepted to date from 29 states and Canada.

The program has four objectives:

1. To evaluate the present health status of the patient through extensive laboratory and x-ray studies and physical examination;
2. To educate the patient on the proper way to lose weight through correct diet and exercise;
3. To help the patient lose weight while in the hospital; and
4. To evaluate the causes of obesity through clinical findings and extensive in-depth interviews.

TOPS is a non-profit organization founded and headquartered in Milwaukee since 1948. Mrs. Esther S. Manz has been president of the group since she originated the idea.

TOPS is based on the principle of "group therapy." Group therapy in TOPS means getting together a group of people who have a common problem—overweight—and discussing it frankly without fear of being laughed at or misunderstood. TOPS is not a "course" of short duration, but a planned, continuing program dedicated to helping the overweight. The program has no "gimmicks" or "fads." Members get their weight goals and diets from their own physicians and TOPS provides them with the incentive to stick to the program through friendly fellowship.

* * *

CANCER IN CHILDREN—A newly released American Cancer Society film for physicians and medical students, describes the significant features of Wilms's tumor, neuroblastoma, intracranial neoplasms, leukemia and rhabdomyosarcoma. Screening of this 27 minute film may be arranged through your local ACS office.

OBITUARIES

Dr. Alfred W. Peelen, 66, Milwaukee physician for 33 years, died Apr. 2, 1968.

Doctor Peelen graduated from Marquette University School of Medicine in 1932 and interned at St. Mary's Hospital, Milwaukee.

Surviving are two sons, Thomas, Oak Creek, and James, Milwaukee; and two daughters, Mrs. Kathleen Motz and Mrs. Judith Kaluzny, Milwaukee.

Dr. Earl W. Martens, 61, Milwaukee, died April 8, 1968, in Milwaukee.

Doctor Martens graduated from the Marquette University School of Medicine in 1932, his internship and residency training were taken at Milwaukee County General Hospital, and graduate study in EENT finished at the University of Pennsylvania. He was a veteran of World War II, serving as a captain from 1942 to 1944 and a major from 1944 to 1946 in the United States Army Medical Corps.

Doctor Martens was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. He was certified by the American Board of Otolaryngology and a member of the Milwaukee Oto-ophthalmic Society.

Surviving are his widow, Viola; and two sons, Dr. William E., Milwaukee, and Robert F., DeKalb, Ill.

Dr. Charles Nobel Lewis, 66, Madison, died Apr. 19, 1968, in Madison.

Doctor Lewis graduated from the University of Wisconsin School of Medicine in 1931. Doctor Lewis was head of the Antibiotics Department of the Food and Drug Administration in Washington, D. C. for 24 years. Before going to Washington, Doctor Lewis was physician to the University of Wisconsin Athletic Department. He was co-author of an antibiotic medical textbook and published several articles on antibiotics in medical journals.

Surviving are his widow, Mildred; and two sons, Charles Jr., Boston, Mass., and Byron, Madison.

Dr. Frank C. Kinsman, 71, Eau Claire, died Apr. 20, 1968, in Eau Claire.

Doctor Kinsman graduated from the Minnesota Medical School in 1920 and interned at St. Mary's Hospital, Minneapolis. In 1922, he started his practice in Eau Claire until his retirement in 1958.

He was railway surgeon for the Chicago Northwestern Railroad and air medical examiner for Federal Aviation Agency. Doctor Kinsman was a veteran of World War I and a member of the American Legion. He was an honorary staff member of Sacred Heart and Luther hospitals in Eau Claire, since his retirement.

Doctor Kinsman was a member of the Eau Claire–Dunn–Pepin County Medical Society, the State Medical Society of Wisconsin and American Medical Association.

Surviving are his daughter, Mrs. Patrick J. Finucane, Eau Claire; and two sons, Frank, St. Louis, Mo., and Richard of Wausau.

Dr. George Frank Malin, 64, La Crosse, died Apr. 22, 1968 in La Crosse.

Doctor Malin graduated from the University of Minnesota Medical School in 1931 and served his internship and surgical residency at Santa Clara County Hospital, San Jose, Calif. Doctor Malin did postgraduate work in urology at Minnesota and the University of Pennsylvania, Philadelphia. He was certified by the American Board of Urology and practiced in Kankakee, Ill. In 1958 he retired and returned to La Crosse.

Doctor Malin was a member of the North Central section of the American Urological Association and the American Medical Association.

Surviving is his widow, Hazel; and a son, Frank Richard, a medical student at the University of Minnesota.

Dr. George M. Shewalter, 77, retired Green Bay physician, died Apr. 27, 1968, in Clearwater, Fla.

Doctor Shewalter graduated from Indiana University School of Medicine in 1916, and was a veteran of World War I.

Surviving are two sons; George and Kenneth, Green Bay, and two daughters; Mrs. Bert (Marilyn) Noh, Clearwater, and Mrs. Philip (Vivien) Geyer, Cape Kennedy, Fla.

* * *

BOOKLET: REGIONAL MEDICAL PROGRAMS

A special communication, which was presented verbally before the Conference-Workshop on Regional Medical Programs last January by Dwight L. Wilbur, M.D., President-Elect of the American Medical Association, has been produced in reprint form. The four-page article, "Quality and Availability of Health Care Under Regional Medical Programs," was published originally in the March 11 issue of JAMA.

In Dr. Wilbur's opinion, the act (Regional Medical Programs authorized under Public Law 89–239) is quite extraordinary in many respects. "The diverse interpretations among various observers of its long-term objectives suggest many misunderstandings and an uncertain but hopefully great future," Dr. Wilbur points out.

To secure a copy of this informative reprint, simply direct your request to the AMA Program Services Department, 535 North Dearborn Street, Chicago, Ill. 60610.

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[1] Gale, E. T. and Thewlis, M. W., Geriatrics 8:80, 1953
[2] Personal Communication: R. C. Brunner, Pharmaceutical Div., Sunkist Growers

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Blatnik, Donald S., U. S. Quarantine Station, Staten Island, N. Y. 10305
Bostian, K. Eugene, 500 West Milwaukee St., Janesville 53534
Breister, Karl A., 205 E. Walnut St., Green Bay 54301
Burnell, Ernest L., 3240 North 3rd St., Milwaukee 53212
Burgoyne, F. H., St. Joseph's Hospital, Marshfield 54449
Datka, Gordon L., 5621 Boy Scout Rd., Indianapolis, Ind. 46226
Dieruf, William J., 12233 West Dearborn Ave., Wauwatosa 53226
Dietsche, Wolfgang O. W., 410 Dewey St., Wisconsin Rapids 54494
Doty, John W., 1300 University Ave., Madison 53706
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Gottschalk, Paul G., 630 South Central Ave., Marshfield 54449
Harrison, Charles S., 4220 North 70th St., Milwaukee 53216
Healy, William G., Pember Nuzum Clinic, Janesville 53534
Kauffman, Herbert M., 8700 West Wisconsin Ave., Milwaukee 53226
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Kirsch, John M., 16025 Heritage Lane, New Berlin 53151
Kuban, Donald J., 2900 West Oklahoma Ave., Milwaukee 53215
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Novacek, Paul J., 400 West Silver Spring Dr., Milwaukee 53217
O'Connor, Thomas A., 2430 West Wisconsin Ave., Milwaukee 53233
Poland, Maynard D., 3003 West Good Hope Rd., Milwaukee 53209
Quackenbush, Robert P., 720 East Wisconsin Ave., Milwaukee 53202
Rich, Ciney R., 1230 West Grant St., Milwaukee 53215
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Yao, Filemon C., 1242 West Court St., Whitewater 53190
Young, Carol E., 3610 North Oakland Ave., Milwaukee 53211

REINSTATED

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Belson, M. J., Fort Polk, La., to 130 E. Walnut St., Green Bay 54302
Beltaos, Efstathios, Milwaukee, to #1 Killideomion #45, T. T. #145, Athens, Greece
Bogle, Warren C., 400 West Silver Spring Dr., Milwaukee 53217
Brittin, Geoffrey M., Madison, to 71 Canyon Road, San Francisco, Calif. 94112
Bryant, David G., Silver Bay, Minn., to 1429 East Skyline Dr., Madison 53705
Conmy, Michael F., 2711 West Wells St., Milwaukee 53208
Damon, Richard A., 708 Scott St., Beaver Dam 53916
Evenson, Roland G., 735 Jefferson St., Sturgeon Bay 54235
Fitzpatrick, Paul J., Milwaukee, to 2420 Merlin Way, Brookfield 53005
Fruchtman, Martin Z., 1215 Downing Dr., Waukesha 53186
Hiller, Samuel J., Milwaukee, to 5415 North Shoreland Ave., Whitefish Bay 53217
Hollenbeck, Stanley W., 6001 West Center St., Milwaukee 53210
Jackson, E. Basil, Milwaukee, to 1220 Dewey Ave., Wauwatosa 53213
James, Richard L., 5656 South Packard Ave., Cudahy 53110
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Kuzdas, James R., Milwaukee, to 8410 West Cleveland Ave., West Allis 53227
Liebenow, Roland R., 309 Lakeview, Lake Mills 53551
Lipscomb, Charles R., Milwaukee, to 13105 Kittridge Ct., Brookfield 53005
McAweeney, William J., Columbia, South Carolina, to 6409 Landfall Dr., Madison 53705
Mielke, John E., 424 East Longview, Appleton 54911

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Pandazi, Andrew A., 811 East Wisconsin Ave., Milwaukee 53202
Parnell, Francis W., Jr., 2429 Allied Dr., Madison 53711
Pettera, Robert L., Washington, D. C., to HHC 9th Infantry Division, APO San Francisco, Calif. 96370
Rosmann, Hermann K., Winnetka, Ill., to Rt. 1, Box 188A, Hayward 54843
Roth, Earl J., 1111 Langlade Road, Antigo 54409
Schultz, William F., Kiel, to 1836 Wisconsin Ave., New Holstein 53061
Spitz, Milton B., 1212 West Wisconsin Ave., Milwaukee 53233
Squier, Theodore L., 925 East Wells St., Milwaukee 53202
Steiner, Robert E., 811 East Wisconsin Ave., Milwaukee 53202
Stewart, William C., 8605 West Lawrence Ave., Milwaukee 53225
Unger, George F., Milwaukee, to V.A. Center, Wood 53214
Usow, Eugene J., 1212 West Wisconsin Ave., Milwaukee 53233
Villacrez, J. A., 810—19 Ave., Monroe 53566
Wagner, George R., Menomonee Falls, to 2319 West Auer Ave., Milwaukee 53206
Waterhouse, Blake E., Ft. Hood, Tex., to 30 South Henry St., Madison 53703
Wunsch, Charles A., Green Bay, to 9035 Watertown Plank Rd., Wauwatosa 53226
Zawodny, Stanley E., Milwaukee, to 8410 West Cleveland Ave., West Allis 53227
Zimmermann, Burton M., 1212 West Wisconsin Ave., Milwaukee 53233

REMOVED FROM MEMBERSHIP

Adam, Alan B., Milwaukee County, resigned
Bates, Donald E., Jefferson County, removed per County Secretary
Busby, Walter W., Milwaukee County
Casey, James H., Milwaukee County, transferred to California
Christopher, Chris C., Sr., Milwaukee County
Hickey, Robert C., Dane County, transferred to Texas
Gunn, Walter G., Milwaukee County
Johnson, Frances, Milwaukee County
Matus, Simon, Milwaukee County
Osher, Norman W., Milwaukee County
Puls, Thomas B., Milwaukee County
Rosenthall, Stoyan P., Milwaukee County
Sealby, Robert L., Shawano County, transferred to Colorado

DEATHS

Knutson, Oscar, Eau Claire–Dunn–Pepin, Mar. 10, 1968
Kehl, Kenneth C., Racine County, Mar. 11, 1968
Stebbins, W. W., Dane County, Mar. 12, 1968
Neacy, Clement F., nonmember, Mar. 19, 1968
Houghton, John H., Columbia–Marquette–Adams, Mar. 25, 1968
Reinke, Christoph C., Milwaukee County, Mar. 29, 1968
Peelen, Alfred W., nonmember, Apr. 2, 1968

* * *

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"DETERMINATION OF NEED FOR MEDICAL EVALUATION IN DRIVER LICENSING"

A new attack has been launched on the problem of providing a more adequate method of determining the fitness of applicants for driver's licenses. The spearhead of the attack is a new guide, "Determination of Need for Medical Evaluation in Driver Licensing," just developed by the AMA Committee on Medical Aspects of Automotive Safety.

This guide, aimed at non-medical licensing authorities, suggests a screening procedure to be used on all license applicants, with only those seeming to present an unwarranted risk as drivers being required to have an examination by a physician. To do such screening effectively, lay licensing authorities will have to have medical advice and guidance. The Committee on Medical Aspects of Automotive Safety suggests that state medical association committees on automotive safety work very closely with state licensing authorities and also with county medical societies.

In addition to improving licensing procedures, the AMA Committee feels that this new guide will go a long way toward eliminating agitation for legislation which would require medical examinations for *all* drivers, as well as that which proposes compulsory reporting by physicians of conditions in their patients which might make driving unsafe. Both of these principles have been opposed by the medical profession for many reasons, principally that they are unworkable. In addition, the compulsory reporting proposal is felt to interfere with the confidentiality of medical records as well as with the traditional physician–patient relationship.

"Determination of Need for Medical Evaluation in Driver Licensing" was published originally in the March 4th issue of The Journal of the American Medical Association, and reprints were distributed April 5 to state medical associations. Individual copies may be obtained from the Committee on Medical Aspects of Automotive Safety, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

the wisconsin medical journal

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CONTENTS

Vol. 67, No. 7 JULY 1968

SCIENTIFIC ARTICLES

Ovarian Pregnancy Removed Via Culpotomy, by Carl J. Levinson, M.D., Milwaukee ... 317

Coronary Atherosclerosis; A Metabolic Defect or a Natural Process of Aging?, by James W. Jefferson, M.D., Madison ... 321

Augmentation Mammaplasty, by Donald M. Levy, M.D., Milwaukee ... 329

Therapeutic Dilemmas: Regional Enteritis (No. 9 of a Series), by Harry Beckman, M.D., Milwaukee ... 334

Comments on Treatment: Oral Hypoglycemic Compounds, by Joseph A. Glennon, M.D., Madison ... 341

SPECIAL FEATURES

Mechanisms of Action of Radiotherapy and Chemotherapeutic Adjuvants (abstract) ... 328

Clinical Spectrum of Primary Tuberculosis in Adults: Confusion with Reinfection in Pathogenesis of Chronic Tuberculosis (abstract) 333

Serologic Evidence for Human Infection with Adenovirus-Associated Viruses (abstract) 340

Surgical Implications of Salmonellosis (abstract) ... 340

Cardiopulmonary Resuscitation at University of Wisconsin (abstract) ... 342

Minutes of Council Meeting: Milwaukee, May 12, 1968 ... 349

Minutes of Council Meeting: Milwaukee, May 15, 1968 ... 352

Medical Memo: Museum of Medical Progress and Stovall Hall of Health ... 28

New Telephone Number of the State Medical Society of Wisconsin ... 32

New Listing Toll-Free Medical Tape Lectures 65

EDITORIALS

President's Page: Have a Complaint? See Your Grievance Committee, by W. D. James, M.D., Oconomowoc ... 343

Paradox and Perspective in the Practice of Medicine, by Leslie G. Kindschi, M.D., Monroe ... 344

Deep Footprints ... 345

Are We Well Fed? ... 346

REGULAR FEATURES

Publication Information ... 6

Medical Meetings ... 7

Letters ... 347

The Medical Student Forum ... 348

Medical Green Sheet ... 353

State Medical Society ... 29

Physician News ... 35

County Societies ... 37

Specialty Societies ... 40

Section on Ophthalmology ... 41

Paramedical/Ancillary ... 55

Society Records ... 61

Obituaries ... 63

Bookshelf ... 66

Physicians Exchange ... 68

Index to Advertisers ... 70

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Journal
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Annual Subscription ... $10.00
Single Copy ... 1.50
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ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago, Illinois 60610; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin 54481.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.

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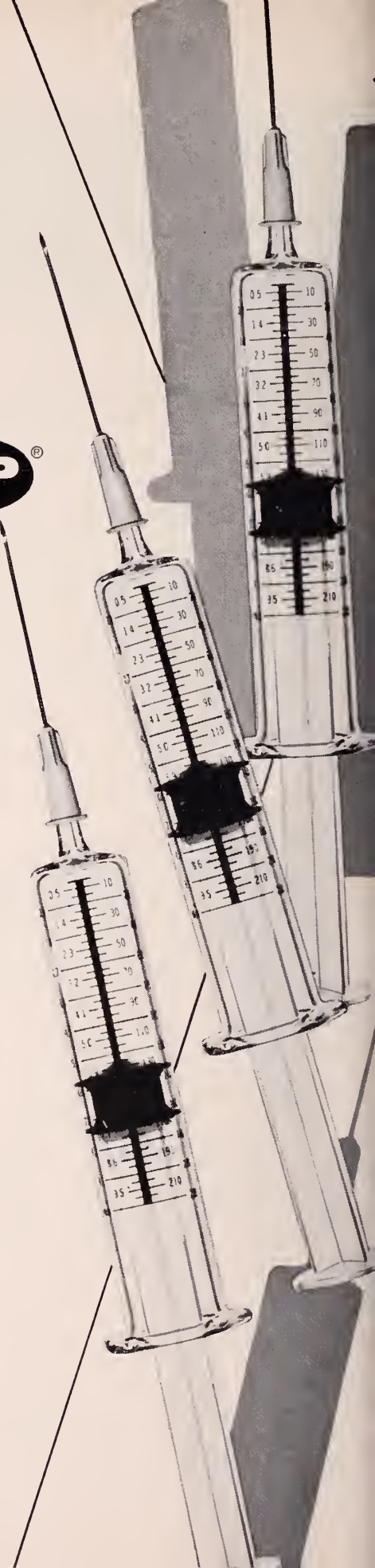

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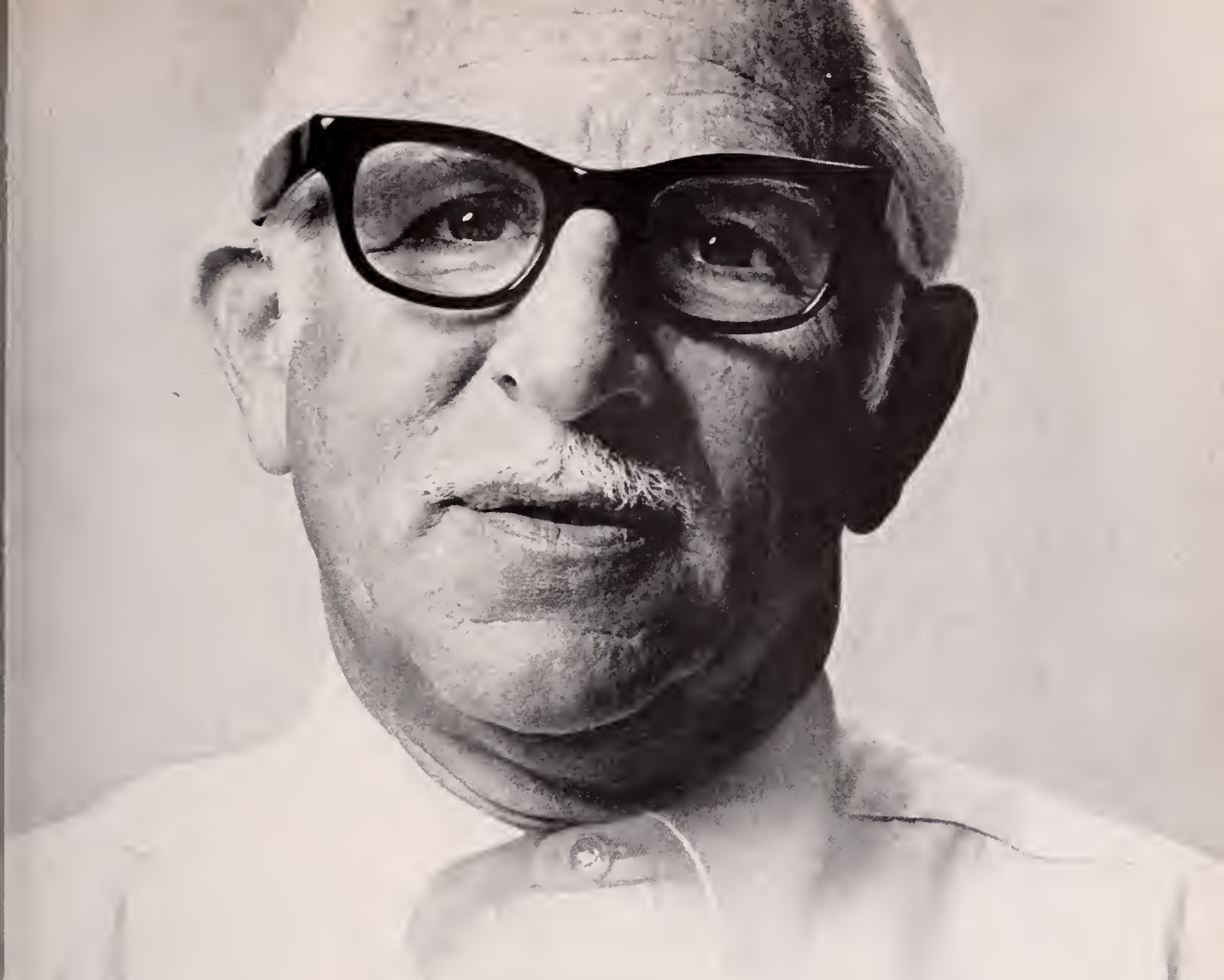

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ıindication: History of hypersensitivity to demethylchlortetracy-
ır nystatin.

ng: In renal impairment, usual doses may lead to excessive accumu-
and liver toxicity. Under such conditions, lower than usual doses
dicated, and, if therapy is prolonged, serum level determinations
e advisable. A photodynamic reaction to natural or artificial sun-
ıas been observed. Small amounts of drug and short exposure may
ce an exaggerated sunburn reaction which may range from ery-
to severe skin manifestations. In a smaller proportion, photo-
c reactions have been reported. Patients should avoid direct
ıre to sunlight and discontinue drug at the first evidence of skin
ıfort. Necessary subsequent courses of treatment with tetracy-
should be carefully observed.

stant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 WISCONSIN

Aug. 22–24: Wisconsin "Cancer Chemotherapy 1968" conference course for physicians, Division of Clinical Oncology, University of Wisconsin Hospitals, Madison.

Aug. 22–24: Workshop on "Exercise as a Therapeutic Tool in Coronary Heart Disease," University of Wisconsin Medical Center and the University Extension in conjunction with the Department of Physical Education—Men, Madison.

Sept. 12–14: Fall meeting, Wisconsin Society of Internal Medicine, Oshkosh, at The Pioneer.

Sept. 14–15 (tentative): Fall meeting, Wisconsin Otolaryngological Society.

Sept. 14–15: Fall meeting, Wisconsin Society of Anesthesiologists, Lake Geneva, at the Playboy Club.

Sept. 20–22: Fall meeting, Wisconsin Radiological Society, Lake Geneva, at the Playboy Club.

Sept. 21: Fall meeting, Wisconsin Surgical Society, St. Mary's Hospital, Madison.

Sept. 25: 1968 Wisconsin Heart Association–Adolf Gundersen Medical Foundation Symposium on Hypertension, Wisconsin State University at La Crosse.

Sept. 25–26: Annual meeting, Wisconsin Academy of General Practice, Pfister Hotel, Milwaukee.

Oct. 1–4: Sixth annual Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Oct. 2: Pulmonary Thromboembolism Conference, sponsored by The Wisconsin Regional Medical Program, Coffey Auditorium, Milwaukee County Hospital, Milwaukee.

Oct. 3: Pulmonary Thromboembolism Conference, sponsored by The Wisconsin Regional Medical Program, Employers Insurance Company of Wausau, Wausau.

Oct. 5: 14th Annual Fall Cancer Conference (The Cancer Scrimmage), University of Wisconsin Medical Center, Madison.

Oct. 8–11: Meeting of the Wisconsin Nurses Association, Sheraton–Schroeder Hotel, Milwaukee.

Oct. 9–10: Meeting of Wisconsin Division, American Cancer Society, Oshkosh.

Nov. 16: Fall annual meeting of Wisconsin Society of Pathologists, Marquette School of Medicine, Milwaukee.

1968 NEIGHBORING STATES

Aug. 17–18: Council and Board of Directors Meeting, American Society of Anesthesiologists, Chicago.

Sept. 23–Oct. 4: PG course in Laryngology and Bronchoesophagology, Department of Otolaryngology of the Illinois Eye and Ear Infirmary and College of Medicine of the University of Illinois at the Medical Center, Chicago.

Sept. 26–29: "The Metabolic Basis of Heart Disease," American College of Physicians, Wayne State University School of Medicine, Detroit, Mich.

Oct. 12–18: Annual Otolaryngologic Assembly of 1968, Illinois Eye and Ear Infirmary at the Medical Center, Chicago, Ill.

Oct. 19–24: Annual meeting, American Academy of Pediatrics, Palmer House Hotel, Chicago, Ill.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

1968 OTHERS

Aug. 1–3: Postgraduate course in Dermatology, University of Colorado School of Medicine, Aspen, Colo.

Aug. 5–8: Postgraduate course in Pediatrics, University of Colorado School of Medicine, Aspen, Colo.

Sept. 7–11: Second International Congress of the Transplantation Society, Americana Hotel, New York City.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo.

Sept. 25: "The Coronary Care Unit—Acute Myocardial Infarction," American College of Cardiology, St. Vincent's Hospital and Medical Center of New York, New York, N.Y.

Sept. 26–29: "The Metabolic Basis of Heart Disease," American College of Physicians, Wayne State University School of Medicine, Detroit, Mich.

Sept. 28–Oct. 3: Western Hemisphere Congress, International College of Surgeons, Honolulu, Hawaii.

Oct. 4–8: Tenth International Congress on Diseases of the Chest, ACCP, Washington Hilton Hotel, Washington, D.C.

Oct. 6–11: XVI Biennial International Congress, International College of Surgeons, Tokyo, Japan.

Oct. 7–12: "Stress and Disease—The Relationship of Psychologic and Social Forces in Pathogenic Mechanisms, American College of Physicians, University of Oklahoma Medical Center, Oklahoma City, Okla.

Oct. 9–11: 15th Western Cardiac Conference, University of Colorado Medical Center, Denver, and Colorado Heart Association.

Oct. 15–18: 51st Annual Meeting, American Dietetic Association, San Francisco, Calif.

Oct. 16–26: Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, International College of Surgeons.

Oct. 21–25: "Current Concepts of Neurology—Diagnosis and Treatment," American College of Physicians, University of Maryland School of Medicine, Baltimore, Md.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

Oct. 26–Nov. 11: Around-the-World Postgraduate Clinics, International College of Surgeons, India, Egypt, Holy Land, Israel, and Greece.

Oct. 28–Nov. 1: "Rheumatic Diseases—Pathology Diagnosis and Treatment, American College of Physicians, Harvard Medical School (Robert B. Brigham Hospital), Boston, Mass.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

Nov. 11–14: Interstate Postgraduate Medical Association Assembly, Pittsburgh, Pa.

Nov. 11–15: "Cancer and Internal Medicine," American College of Physicians, Memorial Hospital for Cancer and Allied Diseases, New York, N.Y.

Nov. 13–16: Forty-seventh annual convention, National Easter Seal Society for Crippled Children and Adults, Sheraton-Boston Hotel, Boston, Mass.

Nov. 19–20: 22nd Annual Meeting, American Heart Association Council on Arteriosclerosis, Bal Harbour, Fla.

Nov. 20–22: Sixtieth annual conference, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

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MEDICAL MEETINGS *continued*

Nov. 21–24: 41st Scientific Sessions, American Heart Association, Bal Harbour, Fla.

Nov. 22–23: Psychedelic Drugs meeting, The Hahnemann Medical College and Hospital of Philadelphia, Pa.

Nov. 25–26: Annual Assembly Meeting, American Heart Association, Bal Harbour, Fla.

Nov. 25–26: Meeting, American Society of Nephrology, Shoreham Hotel, Washington, D.C.

Dec. 2–6: "Physical Methodology in Medical Research," American College of Physicians, Massachusetts Institute of Technology, Cambridge, Mass.

Dec. 10–13: "Cardiology—1968," Institute for Cardiopulmonary Diseases of Scripps Clinica dn Research Foundation, American College of Cardiology, La Jolla, Calif.

Dec. 13–15: "Advances in Coronary Artery Disease," American College of Cardiology, Waldorf–Astoria Hotel, New York, N.Y.

1968 AMA

Oct. 5–6: Second National Congress on Medical Ethics, Judicial Council of the AMA, Drake Hotel, Chicago, Ill.

Dec. 1: Tenth National Conference on the Medical Aspects of Sports, AMA, Hotel Deauville, Miami Beach, Fla.

Dec. 1–4: Clinical Convention, AMA, Miami Beach, Fla.

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1969 NEIGHBORING STATES

Apr. 30–May 4: M.A.C. VI-Midwest Anesthesiology Conference, Illinois Society of Anesthesiologists, Palmer House, Chicago.

1969 OTHERS

Jan.: AHA Council on Clinical Cardiology—"Cardiopulmonary Physiology," San Francisco, Calif.

Apr.: AHA Council on Clinical Cardiology—"Clinical Electrocardiography and Vectorcardiography," Augusta Ga.

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

June: AHA Council on Clinical Cardiology, title and location to be announced.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Winter: AHA Council on Clinical Cardiology—"Clinical Use of Cardiovascular Drugs," La Jolla, Calif.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

AMA National Congress on Medical Ethics

The Judicial Council of the American Medical Association has announced that its Second National Congress on Medical Ethics will be held in Chicago at the Drake Hotel on Oct. 5–6.

This year's program will be a practical consideration and application of ethical principles in everyday practice. It will run the gambit of questions from relationships with ancillary personnel to the ethics of transplanting hearts and lungs. Distinguished speakers from all over the country have agreed to participate in the program.

Attendance will be limited. Early registration is encouraged.

Interstate Scientific Assembly Nov. 11–14

The 53rd annual scientific assembly of the Interstate Postgraduate Medical Association has been planned for Nov. 11–14 at the Pittsburgh Hilton Hotel in Pittsburgh, Pa.

A list of distinguished lecturers includes the following physicians: Edward A. Banner, Rochester, Minn.; Boris Senior, Boston, Mass.; Robert M. Zollinger, Columbus, O.; Kaye H. Kilburn, Durham, N.C.; Edward H. Rynearson, Rochester, Minn.; H. Hoyle Campbell, Toronto, Ont., Can.; James Leonard, Donald Leon, and James Shaver, Pittsburgh, Pa.; Charles R. Shuman, Philadelphia, Pa.; T. S. Danowski, Pittsburgh, Pa.; Sean Mullan, Chicago, Ill.; Dwight C. Hanna III, Pittsburgh, Pa.; Leon I. Goldberg, Atlanta, Ga.; E. S. Gordon, Madison, Wis.; Leonard L. Lovshin, Cleveland, O.; Herbert D. Adams, Boston, Mass.; Vinton E. Siler, Cincinnati, O.; Edward T. Bowe, New York City; Alton Ochsner, New Orleans, La.; and William H. Masters, St. Louis, Mo.

Jerome Y. Lettvin, M.D., Ph.D., M.I.T. of Cambridge, Mass., will be speaker at the dinner program Nov. 13 on the subject "Drug Abuse: The Iatrogenic Disease."

Several social functions have been arranged in conjunction with the scientific program.

This program is acceptable for 23 elective hours by the American Academy of General Practice. Advance registration fee: $15, to Interstate Postgraduate Medical Association, 333 North Randall Ave., Madison, Wis. 53706.

Heart Association's Scientific Sessions

Eight sessions on Clinical Cardiology of special interest to the practicing physician and concurrent programs on various aspects of cardiovascular research are scheduled for the American Heart Association's 41st annual scientific sessions. Extended to four days this year for the first time, the meeting is scheduled from Thursday, Nov. 21 through Sunday, Nov. 24, at the Americana Hotel, Bal Harbour, Fla.

Highlighting the clinical program are the presentation of papers on clinical investigations as well as lectures, panels and symposia. Featured will be the Association's International Lecture by Prof. G. J. V. Nossal of Victoria, Australia, on the timely topic, "Immunological Tolerance—Organ Transplantation —Fair Prospect or Fanciful Folly?"

The simultaneous scientific sessions, planned by the Association's nine scientific Councils, include seven programs on cardiovascular surgery, two sessions on cerebrovascular disease, and reports in other subspecialties of cardiovascular research and medicine.

Registration forms for the sessions, which include hotel reservation requests and additional program information may be obtained through community Heart Associations or the AHA National Office, 44 East 23rd Street, New York, N.Y. 10010.

Five Council Seminars, AHA's Sessions

Five all-day postgraduate seminars on various aspects of cardiovascular disease will be held in conjunction with the American Heart Association's annual scientific sessions, Nov. 21–24, in Bal Harbour, Fla.

Under sponsorship of five of the Association's nine scientific Councils, the seminars are set for Wednesday, Nov. 20, in the Americana Hotel. The AHA scientific program runs from Thursday through Sunday, Nov. 21–24, also in the Americana.

Intended primarily for members of the Councils, the seminars have been planned to be of equal interest to physicians and scientists generally.

The sponsoring Councils and their seminars are:

Council on Rheumatic Fever and Congenital Heart Disease: "Cardiovascular Problems of the Adolescent and Young Adult with Congenital Heart Disease."

Council for High Blood Pressure Research: "Antihypertensive Drug Therapy."

Council on Circulation: "Neural and Humoral Mechanisms of Peripheral Vasodilatation."

Council on Basic Science: "Cardiovascular Mechanics: Definition of Terminology and Problems—A Report on 1968 Summer Workshop."

Council on Cardiovascular Surgery: "Cardiac Transplantation" and "Myocardial Revascularization."

Fees for attending the courses are $10 for Council members, and for residents or research fellows they sponsor, and $25 for others. Advance registration is necessary. For additional information and registration forms, contact Dr. Alfred M. Bennett, AHA, 44 East 23rd Street, New York, N. Y. 10010.

Arteriosclerosis Council to Meet

The 1968 annual meeting of the American Heart Association's Council on Arteriosclerosis will be held on Tuesday, Nov. 19 and Wednesday, Nov. 20, in the Balmoral Hotel, Bal Harbour, Fla., immediately preceding the Heart Association's annual scientific sessions program. The Council meeting is open to all interested physicians and scientists.

Vectorcardiography—A Workshop

An intensive five-day program covering the field of vectorcardiography and related areas is being planned by the American College of Cardiology. Major emphasis is placed on theoretical and practical application of the technique as related to patient's diagnostic problems. The participants will engage in the practice of recording the tracings and in the interpretation of vectorcardiograms. Half of the program is dedicated to individual analysis of the routine vectors by the participants under the orientation of the guest and local faculty. This program is intended for those physicians who wish a close exposure to the value and limitations of vectorcardiography. Advance registration is required and it is limited to 25. For information please write, Administrative Assistant, Institute for Cardiovascular Diseases, Good Samaritan Hospital, 1003 East McDowell Road, Phoenix, Arizona 85002. This is an official postgraduate course of the American College of Cardiology.

International Surgeons Meeting, Japan

Surgeons and surgical specialists from virtually every country of the world will gather in Tokyo, Japan, beginning Oct. 6 for the Sixteenth Biennial International Congress sponsored by the International College of Surgeons.

Internationally renowned surgeons who are scheduled to address the convention include: Dr. Christion Barnard, Capetown, South Africa; Prof. Dr. H. Krayenbuhl and Dr. M. E. Muller, Switzerland; Prof. N. C. Louros, Greece; Dr. L. R. Dragstedt, University of Florida in Gainesville; Dr. Thomas E. Starzl, University of Colorado in Boulder; Doctors Edward L. Compere and Philip Thorek, Chicago; Dr. Yasumasa Aoyagi, Japan; Dr. Joseph H. Ogura, Washington University, St. Louis, Mo.; Dr. N. A. Puchkovskaya, U.S.S.R.; Prof. Dr. Fritz Holle, Germany; Prof. Dr. Tord Skoog, Sweden; and Dr. Richard W. Zollinger, Columbus, Ohio.

Other key speakers from the U.S. are Doctors John S. Najarian, University of Minnesota, Minneapolis; Charles D. Kelman, New York, N.Y.; and Ward A. Soans, Kenmore, N.Y.

Featured speakers and papers will center around ten surgical categories: General Surgery, Colon and Rectal Surgery, Obstetrics and Gynecology, Neurosurgery, Thoracic and Cardiovascular Surgery, Orthopedic Surgery, Urology, Plastic Surgery, Otorhinolaryngology, and Ophthalmology.

The subjects to be considered include organ transplantation, pancreas disease, peptic ulcers, bone fractures, cancer of the larynx, phalynx and uterus, and reconstruction surgery.

The congress is open to doctors from all over the world who wish to attend. The registration fee through June 30 is $65.00 and from July 1 to Oct. 6, $80.00. Registration fees or further inquiries can be addressed to: XVI Biennial International Congress, Prof. Dr. Komei Nakayama, Tokyo Women's Medical College, 10 Ichigaya Kawadacho Shinjukuku, Tokyo, Japan, or to: XVI Biennial International Congress, International College of Surgeons, 1516 N. Lake Shore Drive, Chicago, Ill. 60610.

International Surgeons Meeting, Hawaii

Honolulu, Hawaii, is the setting for the first joint meeting of the International College of Surgeon's two Western Hemisphere Federations, from Sept. 28—Oct. 3. This year for the first time the South American Federation will join the nations from the North American, Central American, and Caribbean Federations who will be celebrating their 33rd Annual Congress.

Scientific and clinical sessions will be held for surgeons in every specialty. Among program offerings will be a panel discussion on "Circulatory Assist Devices" with Dr. Alfred Goldman, Chief of Thoracic Surgery, Cedars-Sinai Medical Center, Los Angeles, Calif., acting as moderator. Panel participants are Dr. William Hall, Baylor University College of Medicine, Houston, Tex.; Dr. Adrian Kantrowitz, Director of Surgery, Maimonides Hospital, Brooklyn, N. Y., and Dr. John H. Kennedy, Western Reserve University, Cleveland, Ohio.

Symposium topics concern "The Use and Abuse of Caesarean Operation" moderated by Dr. William J. Blackwell of Northwestern University Medical School, Evanston, Ill.; with Prof. Nicholas Louros,

University of Athens, Greece; Dr. Oscar Blanchard and Dr. Juan Leon, Buenos Aires, Argentina. A second symposium on "Infertility" will be moderated by Prof. Robert W. Noyes, Chairman of the Department of Obstetrics and Gynecology, University of Hawaii, Honolulu.

Doctors from the United States who will present scientific papers include: *Dr. Arno A. Roscher*, California College of Medicine, Los Angeles—"Clinico-Pathological Correlation of Organ Scanning;" *Dr. John R. Lewis, Jr.*, Atlanta, Ga.—"Reconstruction of Female and Male Breast;" *Dr. M. E. Glasscock III*, Los Angeles, Calif.—"Middle Ear Transplants;" *Dr. Carl Davis, Jr.*, University of Illinois College of Medicine, Chicago—"Surgical Management of Endometrionic of the Ileum and Colon;" *Dr. Irving Lichtenstein*, University of California School of Medicine, Los Angeles—"The One Day Hernia: Its Physiology and Result;" and *Dr. Carl B. Sputh*, University of Indiana, Indianapolis—"Nasal Injuries."

The Congress in Honolulu is the first of several outstanding scientific sessions scheduled by the International College of Surgeons. Immediately following this Congress, the XVI Biennial International Congress will be held in Tokyo and Kyoto, Japan, Oct. 6–11 followed by post-congress clinical seminars in other Japanese cities. Scientific and clinical seminars will be held in Hong Kong, Manila, and Bangkok Oct. 13 through 26 terminating in an Around-the-World Tour with a series of postgraduate clinics in India, Lebanon, Israel, and Greece Oct. 26–Nov. 11.

Doctors wishing to attend the Honolulu Congress may send their registration fee directly to the International College of Surgeons, 1516 N. Lake Shore Drive, Chicago, Ill. 60610. The fee is $35.00 for ICS members, $40.00 for non-members and $20.00 for each accompanying adult. Further inquiries on any of the above sessions may also be sent to the above address.

Spinal Cord Injury Course

The second of a series of postgraduate medical courses in the care of spinal cord injury patients will be offered to 30 selected physicians in West Roxbury, Mass., Oct. 21 through Oct. 25, the Veterans Administration has announced.

Experts in spinal cord injury care from VA's specialized centers will lecture and demonstrate treatment techniques on all aspects of the emergency and early care, rehabilitation and continuing care of the spinal cord injury patient.

The course is being conducted without tuition charge to bring the benefits of VA's exceptional experience in this highly specialized field of medicine to the entire medical community.

The West Roxbury course is the second of a series being conducted twice yearly.

The third is tentatively scheduled at Long Beach, Calif., in the spring of 1969. The first course was held in Long Beach this spring.

Applications for attendance may be made to Veterans Administration, Chief of the Spinal Cord Injury Staff, 810 Vermont Ave., NW, Washington, D. C. 20420. Eligibility to attend this course extends to urologists, general surgeons, neurosurgeons, orthopedic surgeons, plastic surgeons, neurologists, and internal medicine specialists.

American Academy of Pediatrics

Infectious mononucleosis—new developments, the current status of organ transplantation, sex education—the parent's role, pediatric aspects of cigarette smoking, the sudden death syndrome, and drug use and abuse in adolescence will be among the subjects examined during the 37th annual meeting of the American Academy of Pediatrics in Chicago, Oct. 19–24.

More than 4500 persons including pediatricians, their families and guests are expected to attend the meeting in the Palmer House Hotel.

The 11th annual meeting of the American Association of Poison Control Centers will be presented on Sunday and Monday, Oct. 20–21. Environmental safety: the challenge to poison control centers, and poison information, storage and retrieval, as well as other subjects, will be reviewed during this meeting.

Easter Seal Convention in Boston

The future role of the voluntary health and welfare agency in a changing society will be explored during the 1968 convention of the National Easter Seal Society for Crippled Children and Adults to be held in Boston, Nov. 13–16.

Hundreds of professional and volunteer leaders from the 50 states, Puerto Rico and the District of Columbia will gather at the Sheraton–Boston Hotel to examine a variety of other subjects relating to rehabilitation. Among them:

1. Increased emphasis on information, referral, and follow-up programs now being instituted by Easter Seal societies to assure that help from all sources is made available to those who need it.
2. The constantly changing requirements of service for the handicapped.
3. New frontiers in rehabilitation facilities.
4. Delivery of services to hard-to-reach patients.
5. Programs on public relations, fund raising, man power and reporting.

In addition, meetings of the National Society's board of directors and house of delegates will be held to determine policy and chart the Society's course during the coming year.

Colorado Medical Courses

The University of Colorado School of Medicine will present a postgraduate course on internal medicine, Aug. 12–16 at the Stanley Hotel, Estes Park. On Sept. 30–Oct. 4, a hospital medical staff conference will be held at the YMCA Conference Center, Estes Park. Details from: Office of PG Education–2736, UC School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

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Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients re ceiving thyroid medication when this compound was added to the regimen.
Imipramine may block the pharma cologic activity of guanethidine a other related adrenergic neuron-blocking agents.
The drug is not recommended at present time in patients under 12 of age.
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New Members of Fifty-Year Club Honored

Edward S. Carlsson, Sr., M.D.

Joseph M. Freeman, M.D.

EDWARD S. CARLSSON, SR., M. D.
La Crosse, Wisconsin

Doctor Carlsson was born on July 24, 1891, in Lindsborg, Kansas. He graduated from Chicago University, Rush Medical School in 1918. Doctor Carlsson is in general practice in La Crosse and is a member of the Wisconsin Society of Obstetrics and Gynecology. He and his wife Pernella have three children: Ingred Ann Fisher; Edward, Jr.; and Reverend John Eben Carlsson.

JOSEPH M. FREEMAN, M. D.
Wausau, Wisconsin

Doctor Freeman was born November 17, 1891, in Sullivan, Indiana. A 1918 graduate of Harvard Medical School, he is in general practice in Wausau. Doctor Freeman has served as both Secretary-Treasurer and President of the Marathon County Medical Society, the 9th Councilor District of the State Medical Society of Wisconsin, and the Wisconsin Society of Obstetrics and Gynecology. He has also been a member of the Commission on Scientific Medicine of the State Medical Society. Doctor Freeman and his wife Jean have two children, Eleanor Johnson and David J. Freeman, M. D.

IN HONOR OF FAITHFUL SERVICE

Annually the State Medical Society of Wisconsin pays its respects to members who have served their profession and patients for 50 years. It is an honor which is expressed by fellow practitioners on behalf of the communities and patients who have been served by physicians of experience and integrity.

On these pages are the names, pictures, and short biographical data of those physicians honored by the Councilors, Officers, and Past Presidents of the Society during the 127th Annual Meeting of the State Medical Society of Wisconsin, in Milwaukee, May 12, 1968.

ARTHUR F. HAAG, M. D.
Eau Claire, Wisconsin

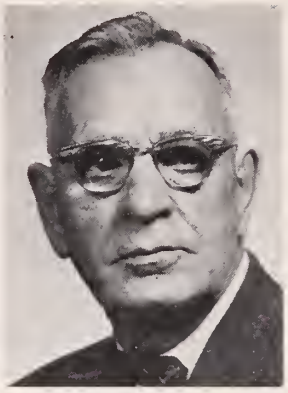
Doctor Haag was born September 7, 1881 near Cadott in Chippewa County, Wisconsin. He graduated from Loyola University Medical College, Chicago, in 1918. He practiced in Chicago until 1926 when he returned to Eau Claire. From 1931 until his retirement in 1961, he was plant physician for the Drummond Packing Company. Dr. Haag served as secretary-treasurer of the staff of Sacred Heart Hospital in Eau Claire for 14 years, and he served in the same capacity for 28 years at Luther Hospital. He was Deputy Coroner for four years, and was County Coroner from 1960–1961. Doctor Haag has three children; Harold, Robert and Gordon. His wife Lucille died in 1962.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JUNE 1968

2 *Marquette Medical School Graduates Luncheon (Milwaukee)*
3 Legislative Advisory Committee, Wisconsin Association of Professions
4 Board of Trustees, Dane County Medical Society
4 Surgical Staff, Madison General Hospital
4 Madison Urological Society
4 Madison Anesthesiology Society
5 Planning Committee, Wisconsin Regional Medical Program
7 Madison Society of Obstetrics and Gynecology
7 SMS Commission on Scientific Medicine
8 Cancer Study Committee, Wisconsin Regional Medical Program
9 SMS Division on Nervous and Mental Diseases of Commission on State Departments
10 Open House for University of Wisconsin Medical School Graduates
10 Advisory Committee on Extended Care Facilities, Dane County Medical Society
10 Executive Committee, SMS Section on Ophthalmology
20 SMS Committee on Occupational Health of the Commission on Health Information
25 SMS Division on Maternal and Child Welfare of the Commission on State Departments
28 Cardiology Study Committee, Wisconsin Regional Medical Program
29 Wisconsin Regional Medical Program
30 SMS President's Reception

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics, with the location in parentheses.

T. Charles Hemmingsen, M.D.



Arthur F. Haag, M.D.

T. CHARLES HEMMINGSEN, M. D.
Racine, Wisconsin

Doctor Hemmingsen was born March 25, 1890 in Racine, Wisconsin. He graduated from Marquette University School of Medicine in 1918 and is in general practice. Doctor Hemmingsen has served as 1st District Councilor to the State Medical Society of Wisconsin, and as president of the Racine County Medical Society, president of the Board of Trustees and of the active staff of St. Luke's Hospital in Racine, and Medical Director of Racine County Hospital. He and his wife Pearl Rose have two children; Charles John, and Janet Alberta Bartos.

ELGIE M. HOUGHTON, M. D.
Lancaster, Wisconsin

Doctor Houghton was born June 27, 1894 in Beetown, Wisconsin. He graduated from Loyola University Medical School, Chicago, in June 1918. Doctor Houghton is in general practice in Lancaster. He and his wife Rose Marie have two married daughters; Mary Lou Niven and Marcia Rose Burr.

ALFRED N. E. MERTEN, M. D.
Milwaukee, Wisconsin

Doctor Merten was born July 16, 1895 in West Bend, Wisconsin. He graduated from Marquette University School of Medicine in 1918 and served with the U. S. Navy on active duty during World War II. Doctor Merten is a general practitioner and member of the Milwaukee Academy of Medicine, American Heart Association and American Society of Geriatrics. He is a former member of the American Association for the Advancement of Science, American Medical Writers Association and Association of Military Surgeons of the U. S. He and his wife Marie have two children; Walter, and Mrs. Florence Fridl.

GEORGE ELKINGTON MOORE, M. D.
Antigo, Wisconsin

Doctor Moore was born April 26, 1890 in Kewaunee, Wisconsin. He graduated from Northwestern University Medical School in 1918. Doctor Moore is a surgeon and general practitioner and a member of the Radiological Society of North America. He lives in Antigo. He has four children; George Jr., Donald, Frederick and William.

AUBREY H. PEMBER, M. D.
Lake Wales, Florida

Doctor Pember was born October 7, 1894, in Janesville, Wisconsin. In June 1918, he graduated from Northwestern University Medical School. Doctor Pember specializes in eye, ear, nose and throat. He was for 8 years an Associate in Ophthalmology at Northwestern and is a fellow of the Academy of Ophtholaryngology, Otolaryngology and Rhinology. Doctor and Mrs. Pember have four children; John F. Pember II, M. D., Charles, Constance and Godfrey.

HANS H. REESE, M. D.
Madison, Wisconsin

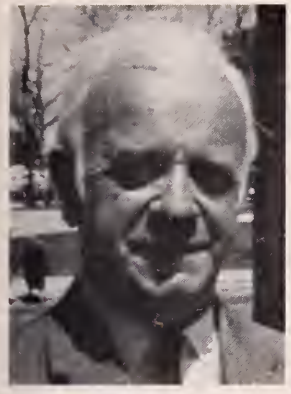
Doctor Reese was born September 17, 1891, in Bordesholm in Holstein, Germany. He received his M. D. degree from the University of Kiel in 1917 and did postgraduate work at the University of Hamburg. He came to this country in 1920, and in 1925 he helped found the neuropsychiatry department at the University of Wisconsin Medical School. He was chairman of the department in 1940, 1946 and 1954–1956, and of the neurology department from 1956–58 He holds an honorary degree from Kyushu University in Japan. He was secretary of the Dane County Medical Society, was a member of the House of Delegates of the AMA, was president and fellow of the College of Psychiatry, and was president of the Milwaukee and North Central Neuropsychiatry Societies. He has served as president of the American Muscular Dystrophy Association, the American Neurological Association and the American Board of Psychiatry and Neurology. Dr. Reese and his wife Tessa have three children; Sibyl, Mrs. Alma Gray, and Dr. E. S. Reese, Professor of Marine Biology.

Elgie M. Houghton, M.D.

Alfred N. E. Merten, M.D.

George Elkington Moore, M.D.

Aubrey H. Pember, M.D.



Hans H. Reese, M.D.

Chester C. Schneider, M.D.

CHESTER C. SCHNEIDER, M. D.
Whitefish Bay, Wisconsin

Doctor Schneider was born February 11, 1894, in Milwaukee. On his birthday in 1918, he graduated from Harvard Medical School. An orthopaedic surgeon, he has been president of the Milwaukee Orthopaedic Club, the Wisconsin Orthopaedic Club, a lecturer of the American Academy of Orthopaedic Surgeons, and diplomate of the American Board of Orthopaedic Surgery. He also has served as president of the International Association of Y's Mens Clubs. He and his wife Belle have three children; Byron, Fredric, and Chester, Jr.

O. A. STIENNON, M. D.
Green Bay, Wisconsin

Doctor Stiennon was born September 19, 1890 in Charleroi, Belgium. He attended Marquette University School of Medicine, and graduated in 1918. Doctor Stiennon is a general practitioner. He is a past president of the Brown County Medical Society, and he was for twelve years a delegate to the State Medical Society of Wisconsin. Doctor Stiennon and his wife Mildred have two sons, Arthur and John.

O. A. Stiennon, M.D.

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It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

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A completely new telephone system, capable of handling all calls without delay, has been installed in the State Medical Society headquarters.

To facilitate efficient and accurate service by the switchboard operator, callers are urged to identify themselves first and then indicate the subject matter such as:

STATE MEDICAL SOCIETY OF WISCONSIN

- Membership and dues
- Committees
- Wisconsin Medical Journal
- Scientific Medicine (annual meeting, postgraduate programs)
- Regional (Field) Services
- CES Foundation
- Public Information (press relations, pamphlets, films)
- Speakers Service
- MDs Life Insurance Program
- Meeting room facilities at 330 (reservations)
- Placement Service
- Meeting dates
- Dane County Medical Society
- Grievance
- Medicolegal Information
- Woman's Auxiliary

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- Physicians' personal WPS health insurance
- Group billing
- Subscriber service (assistance with claims, conversion, and contract information)
- Verification of coverage
- Claims for federal employes
- Ordering claim forms
- WPS Medicare-Plus $15,000 (supplemental coverage to federal medicare)

TITLE XVIII (MEDICARE) and TITLE XIX (MEDICAID)

- Claims on Social Security Medicare—Part B
- Payments for MD charges
- Claims on Title XIX (Wisconsin Medical Assistance Program)

MILITARY MEDICARE (CHAMPUS)

- Claims for dependents of servicemen
- Claims for retired military servicemen

Clip this page and place near your telephone or in telephone directory for convenient referral

Dr. Rueckert On Health Council

Dr. Ray R. Rueckert, Portage, recently was appointed by Governor Warren Knowles, as a member of the Council on Health. Doctor Rueckert succeeds the late Dr. John Houghton, Wisconsin Dells, for the remainder of the unexpired term ending Feb. 1, 1973. He is a graduate of the University of Wisconsin Medical School and also is on three committees of the State Medical Society of Wisconsin.

Dr. Peterson Joins ACOG

Dr. Jack A. Peterson, Waukesha, recently was admitted to The American College of Obstetricians and Gynecologists at the Palmer House, Chicago, Ill.

Dr. Klutzow Terminates Practice

Dr. F. W. Klutzow, Gillett physician for the past 10 years, terminated his practice June 1, 1968, to start a new position July 1 with the Veterans Administration as a career resident in Pathology. Doctor Klutzow served as president of the Oconto County Medical Society, chief of staff of Community Memorial Hospital, Oconto Falls, past president of the Oconto County Cancer Society, member of the American Heart Association, Oconto County committee of Wisconsin Association on Alcoholism, and Oconto County Mental Health Association and City Health Officer. When he completes his training he may be assigned to any Veterans Administration hospital in the country as a pathologist.

Dr. Donovan Accepts New Position

Dr. William N. Donovan, former Madisonian, recently accepted the position as director of medical services at the Wisconsin State Prison, Waupun. Doctor Donovan graduated from the University of Wisconsin Medical School in 1936 and was in the United States Army Medical Corps from 1939 to 1963. He was on the staff of the University of Wisconsin as clinical assistant professor of medicine and also has been employed as public health physician for the city of Milwaukee.

Dr. Weiland Honored at Banquet

Dr. H. P. Weiland, Verona physician and surgeon for the past 47 years, recently was honored at a testimonial dinner in Verona. Doctor Weiland graduated from Loyola University in 1915 and began his practice in Verona in 1921. Doctor Weiland, active in community affairs, started the youth activities in the area.

Dr. Schrock Moves to Elkhorn

Dr. J. B. Schrock recently closed his office in Sharon and began practicing in Elkhorn July 1. Doctor Schrock served the Sharon community for 19 years. The village of Sharon designated May 28 as "Doc's Day."

Dr. Thornton Honored at Dinner

Dr. Madeline Thornton, Madison, recently was honored at alumni Kum Bak dinner of Syracuse University, Syracuse, N.Y. Doctor Thornton was presented the George Arents Pioneer medal, the university's highest award to alumni.

Dr. Siebens Guest Speaker

Dr. Arthur A. Siebens, Madison, recently was the guest speaker at the Sigma Sigma honor fraternity initiation which was held at Rohde's Steak House. The new initiates from the University of Wisconsin Medical School are: Stephen W. Rutter, Craig G. Stien, David D. Nurenburg, Marcia J. Stahmann, Daniel N. Wochos, Samuel M. Cohen, Kenneth Feldman, Stephen A. Bernsten, Leslie A. Leppla, Paul E. Sandstrom, Thomas E. Knechtges, and Michael J. Moore.

Dr. Quick Guest Speaker

Dr. Armand J. Quick, Milwaukee, recently spoke on "A New Concept of Hemostasis" at Medical Grand Rounds, Los Angeles County General Hospital. He also presented "Diagnosis and Management of Familial Bleeding Disorders" at a symposium on RECENT ADVANCES IN BLEEDING DISORDERS sponsored by the California College of Medicine, by the University of California at Irvine and by the Orange County Medical Center, Los Angeles. Doctor Quick recently received his 50-year certificate of membership in the American Chemical Society and attended his 40th Class Reunion of Cornell University Medical College and his 50th Class Reunion of the University of Wisconsin.

Doctors Hold Five-Day Clinic

Dr. J. W. Johnson, Withee, recently headed the Five-Day Plan to Stop Smoking series which was held at the Marshfield Convalescent Center. Drs. V. W. Johnson and *Griffith L. Thomas* of Prentice also participated in the program.

Dr. Hirschboeck Guest Speaker

Dr. John Hirschboeck, Milwaukee, coordinator of the Wisconsin Regional Medical Program, recently spoke before the Fox Valley Academy of Medicine at the North Shore Golf Club, Appleton.

Dr. Bender Joins Clinic

Dr. Joseph P. Bender, Sandstone, Minn., recently joined *Drs. F. M. Bannister* and *G. S. Clarke* at the Chetek Medical Clinic. He graduated from the Ohio State University College of Medicine, Columbus,

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Physicians whose names appear in italics are members of the State Medical Society.

Ohio, in 1965, served his internship at St. Joseph's Hospital, Marshfield, and recently completed two years of service in the United States Public Health Service as Chief Medical Officer, Bureau of Prisons, Sandstone, Minn.

Medical Alumni Elect Officers

Dr. Richard H. Wasserburger, professor of medicine at the University of Wisconsin Medical School, Madison, and a member of the staff of the VA Hospital, assumed the presidency of the UW Medical Alumni Association at the 13th annual meeting of the association May 24.

Dr. Charles Benkendorf of Green Bay was chosen president-elect. A resident at the UW Hospitals from 1955–1958, he has a private practice in radiology and is an associate radiologist at St. Vincent's Hospital, Green Bay. Doctor Benkendorf also is a member of the clinical staff of the UW Medical School's Department of Radiology.

Dr. Sigurd E. Sivertson of Madison (formerly of La Crosse) and *Dr. Roger E. Laubenheimer* of Milwaukee were elected to the association's board of directors.

About 300 physicians attended the annual meeting.

Dr. Lobeck Visiting Professor

Dr. Charles C. Lobeck, professor and chairman, Department of Pediatrics, University of Wisconsin Medical School, Madison, was a visiting professor at the University of Rochester June 4–6. He spoke on "Frontiers of Research in Cystic Fibrosis."

Dr. Hirschboeck Given WHA Award

The Wisconsin Heart Association presented its 1968 Service Award to *Dr. John Hirschboeck* of Milwaukee, this year's campaign chairman, during its 21st annual meeting June 6 at Oshkosh.

Dr. Peterman Returns to Milwaukee

Dr. M. G. Peterman, formerly professor of pediatrics at Marquette School of Medicine, has returned to Milwaukee. Doctor Peterman resigned from his position as senior consultant to the Bureau of Medicine of the Department of Health, Education, and Welfare. He has resumed his consultation practice in pediatric neurology in Milwaukee.

Dr. Laufenburg Joins Cedarburg Colleagues

Dr. Herbert Laufenburg, Cedarburg, recently became associated with *Drs. P. B. Blanchard* and *John Kippenhan* to replace *Dr. Allen Misch* who left to take a residency in Radiology at St. Luke's Hospital, Milwaukee. Doctor Laufenburg graduated from the University of Wisconsin Medical School in 1953 and interned at Milwaukee Lutheran Hospital. He served in the United States Navy for three years, practiced in Shawano, with the federal government in Washington, D. C., and most recently has been Medical Director of American Motors in Milwaukee.

Speak at Head Injury Institute

TWO NEUROSURGEONS, *Dr. Ralph L. Suechting* (seated) of Neenah and *Dr. Bahij S. Salibi* (standing) of Marshfield, were guest speakers at a statewide head injury institute May 21 at Mercy Hospital, Oshkosh. They are pictured here with Mrs. Daniel Flanders, Oshkosh, and Sister M. Denice, in-service coordinator and director of nursing services, respectively. (Photo courtesy *Oshkosh Daily Northwestern*)

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WALWORTH

Hold Annual Medical Seminar

The annual medical seminar and play day for members of the Walworth County Medical Society was held June 5 at the Playboy Club, Lake Geneva. Host for the all-day event was *Dr. R. S. Galgano*, Delavan, president of the society.

Nationally prominent physicians appeared on the morning scientific program which was followed by an afternoon of social activities, climaxed by an evening dinner-dance.

Speakers were *Dr. Joseph F. Kuzma*, professor of pathology and chairman of the department of pathology of Marquette School of Medicine, Milwaukee; Dr. Owen Wangensteen, emeritus professor of surgery at the University of Minnesota and a former chairman of the department of surgery at the university; Dr. Arthur C. Allen, pathologist for the Jewish Hospital, Brooklyn, N. Y., and professor of pathology at the State University of New York in the Downstate Medical Center; Dr. John Adriani, director of anesthesia at Charity Hospital of New Orleans, La., and professor of anesthesia and chairman of the department of anesthesia at Tulane University; and Dr. Charles J. Smith, professor of obstetrics and gynecology at Loyola University and director of obstetrics and gynecology at Mercy Medical Center, Chicago, Ill.

DOUGLAS

Honor Area Pathologist

Members of the Douglas County Medical Society attended a retirement banquet in honor of Dr. George Berdez at St. Mary's Hospital, Superior, late in May. Doctor Berdez, a Superior–Duluth pathologist, was cited "for his pioneer work in the field of medicine, great humanitarianism and unselfish dedication to the area's hospitals over the past 45 years." The Douglas society presented him with a portable color TV set.

LAFAYETTE

Conducts Educational Program for Diabetics

During the month of June the Lafayette County Medical Society participated in an educational program for people who have diabetes and their families. Also assisting at the four sessions were the county public health nurse and the district nutrition consultant of the State Division of Health, along with other local dietitians. The physicians dealt with the medical aspects of the disease. Two sessions included discussion of and assistance with diet programs. The final session was conducted by nurses who discussed home care problems as they relate to personal care and medications.

Physicians whose names appear in italics are members of the State Medical Society.

BROWN

Benefit Party Aids CES Foundation

Dr. and Mrs. *Robert Schmidt* of Green Bay were host and hostess at a benefit party May 26 to members of the Brown County Medical Society and the Woman's Auxiliary. Proceeds of the event are being contributed to two organizations, American Medical Association Education and Research Foundation and Charitable, Educational and Scientific Foundation of the State Medical Society. Both foundations are involved in research and the preservation of state medical history and also grant loans to needy medical students. Mrs. Schmidt is the Brown County Auxiliary CESF chairman. Mrs. John Guthrie served as general chairman of the benefit. She is local and state chairman of the AMA–ERF.

OUTAGAMIE

Farewell Party for Doctor Mueller

Dr. Gilbert F. Mueller, Jr., an Appleton surgeon interested in vascular surgery, was guest of honor at a farewell party given by members of the Outagamie County Medical Society, June 4. The occasion marked the eve of Doctor Mueller's departure for Ceylon where he is now serving a two-month medical tour of duty aboard the hospital ship, SS HOPE.

Society members presented Doctor Mueller with a personal gift, also a purse for the SS HOPE and for patients in need of financial and medical aid.

SS HOPE has become an internationaly known symbol of American good will. Placards seen in the

DR. GILBERT F. MUELLER, JR. of Appleton (right) was presented a personal gift by the Outagamie County Medical Society at a farewell party June 4 before he departed for two months duty on the hospital ship, SS HOPE. *Drs. William W. Chandler and Guy W. Carlson made the presentation. (Appleton Post–Crescent Photo)*

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COUNTY SOCIETIES *continued*

corridors of the ship in different languages of countries previously visited, stating "Yankee Come Back," attest to the popularity of the ship on its medical missions.

The ship is now located in Colombo, the capital city of Ceylon, where it is completing a ten-month program of medical education and assistance for the people of that Southeast Asian island republic.

Doctor Mueller, after arriving in Ceylon, was assigned to the staff of the University Medical School of Koady in the mountains for one month, then returned to the SS HOPE.

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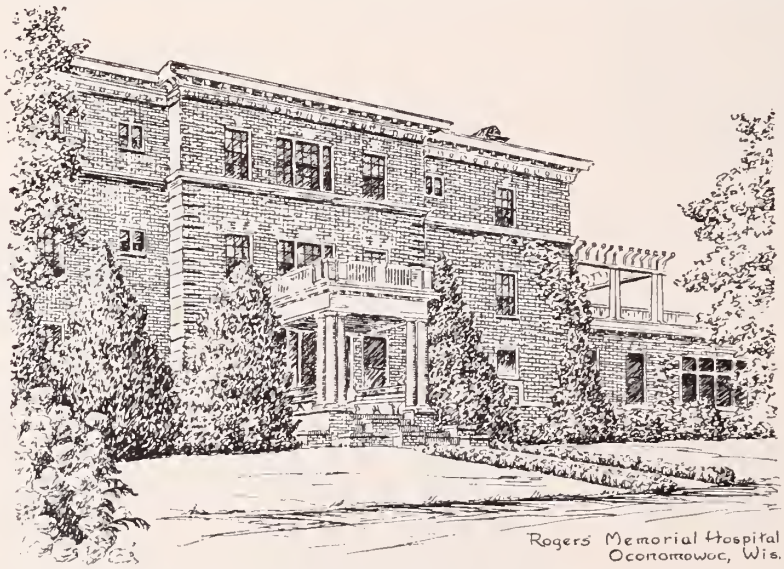

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Medical Director
EUGENE B. FRANK, M. D.
LOREN J. DRISCOLL, M. D.
THOMAS J. GORAL, M. D.
JOHN J. O'HARA, M. D.
EARL F. WEIR, M. D.
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SPECIALTY SOCIETIES

Milwaukee Neuro-Psychiatric Society

At the May 22 meeting of the Milwaukee Neuro-Psychiatric Society the following officers were elected for the coming year: president, *Dr. Preston W. Thomas*; president-elect, *Dr. Charles W. Landis*; secretary, *Dr. William H. Studley*; and treasurer, *Dr. Leo B. Perssion*, all of Milwaukee. Councilors are: *Drs. Jules D. Levin* and *Ervin Teplin* of Milwaukee and *Dr. James A. Alston* of Waukesha.

Section on Anesthesiology

At the May 16 meeting of the State Medical Society Section on Anesthesiology a motion was passed that the president-elect and the secretary of the Wisconsin Society of Anesthesiologists be designated the respective chairman and secretary of the Section. Thus, for the next year the chairman of the Section is *Dr. Robert M. Schuyler* of Milwaukee and the secretary is *Dr. Ruth A. Stoerker* of Madison. The delegate, *Dr. Sheldon Burchman* of Milwaukee, and the alternate delegate, *Dr. John W. Temple* of Wauwatosa, continue in their offices.

Physicians whose names appear in italics are members of the State Medical Society.

Wisconsin Association of PH Physicians

Dr. Thorn L. Vogel, city health commissioner of Janesville, took office in May as president of the Wisconsin Association of Public Health Physicians. The group met in Milwaukee in conjunction with the annual meeting of the State Medical Society of Wisconsin. Secretary-treasurer is *Dr. George H. Handy*, acting assistant state health officer, Madison.

Wisconsin Surgical Society

Dr. K. L. Carter of Beloit was named president-elect of the 200-member Wisconsin Surgical Society when it met in May at Milwaukee in conjunction with the annual meeting of the State Medical Society of Wisconsin. He succeeds *Dr. John T. Mendenhall* of Madison who became president. *Dr. Wilson Weisel* of Milwaukee continues as secretary-treasurer.

* * *

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SECTION OPHTHALMOLOGY

JULY 1968 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Committees Report Activities at Annual Section Meeting

The Section on Ophthalmology of the State Medical Society of Wisconsin met at the Hotel Sheraton–Schroeder in Milwaukee, May 16, following a combined luncheon with the Section on Otolaryngology. Dr. James V. Bolger, Jr. of Waukesha, chairman, presided.

Dr. Carl F. Schmidt of La Crosse, Section delegate to the SMS House of Delegates, reported on the House actions.

The legislative committee chairman, Dr. Herbert Giller of Milwaukee, reported on a number of bills before the Legislature including the bill on safety glass for schools, in laboratories, shops, and similar structures. This bill will be re-introduced by the Wisconsin Society for the Prevention of Blindness. The optician licensing bill, supported by the Section, has not been acted upon. The committee has received a report by the Attorney General concerning tonometry examination by the optometrists. The committee has contacted the State Board of Medical Examiners on the use of the title "Doctor" by unauthorized persons.

Dr. Matthew D. Davis of Madison reported on activities of the education committee. A demonstration on applanation tonometry and showing of a film were included on the SMS annual meeting program. The committee has also helped provide two new tape lectures for the statewide telephone consultation program supported by the Wisconsin Regional Medical Program with the cooperation of the University of Wisconsin and Marquette medical schools.

A report on the activities of the American Association of Ophthalmologists was presented by Dr. Elmer E. Johnson of Madison. Dr. Ralph E. Teitgen of Milwaukee reported on the activities of the Wisconsin Society for the Prevention of Blindness including prevention of blindness in accidents, cooperation with the State Department of Health and Social Services on visual screening, and the school safety glass bill.

Dr. Donald E. Chisholm of Milwaukee reported on the Lions Club program of the Eye Bank. Dr. George Sparks of Marshfield explained the school screening program of the State Department of Health and Social Services and the booklet on Visual Screening offered by the Department.

Dr. Clemens G. Kirchgeorg of Neenah outlined the visual standards committee function in that it is willing to work with any public or private group to help determine and establish visual standards. The committee has been working on visual standards for driving and for athletic physical examinations.

Dr. John R. Allen of Madison explained the purposes and plans for the ophthalmology page in the *Wisconsin Medical Journal.*

The following officers were elected for the coming year:

Richard W. Ashley, MD, Kenosha _____Chairman
Ralph E. Teitgen, MD, Milwaukee _Vice-Chairman
Carl F. Schmidt, MD, La Crosse _____Secretary
William C. Parks, MD, Milwaukee _____Delegate
George H. Anderson, MD, Stevens Point
_____Alternate

Dr. George Nadeau, Jr. of Green Bay, chairman of the nominating committee, commended Doctor Bolger for his fine work in organizing the Section and accomplishing so much during his tenure as chairman. Doctor Bolger declined renomination.

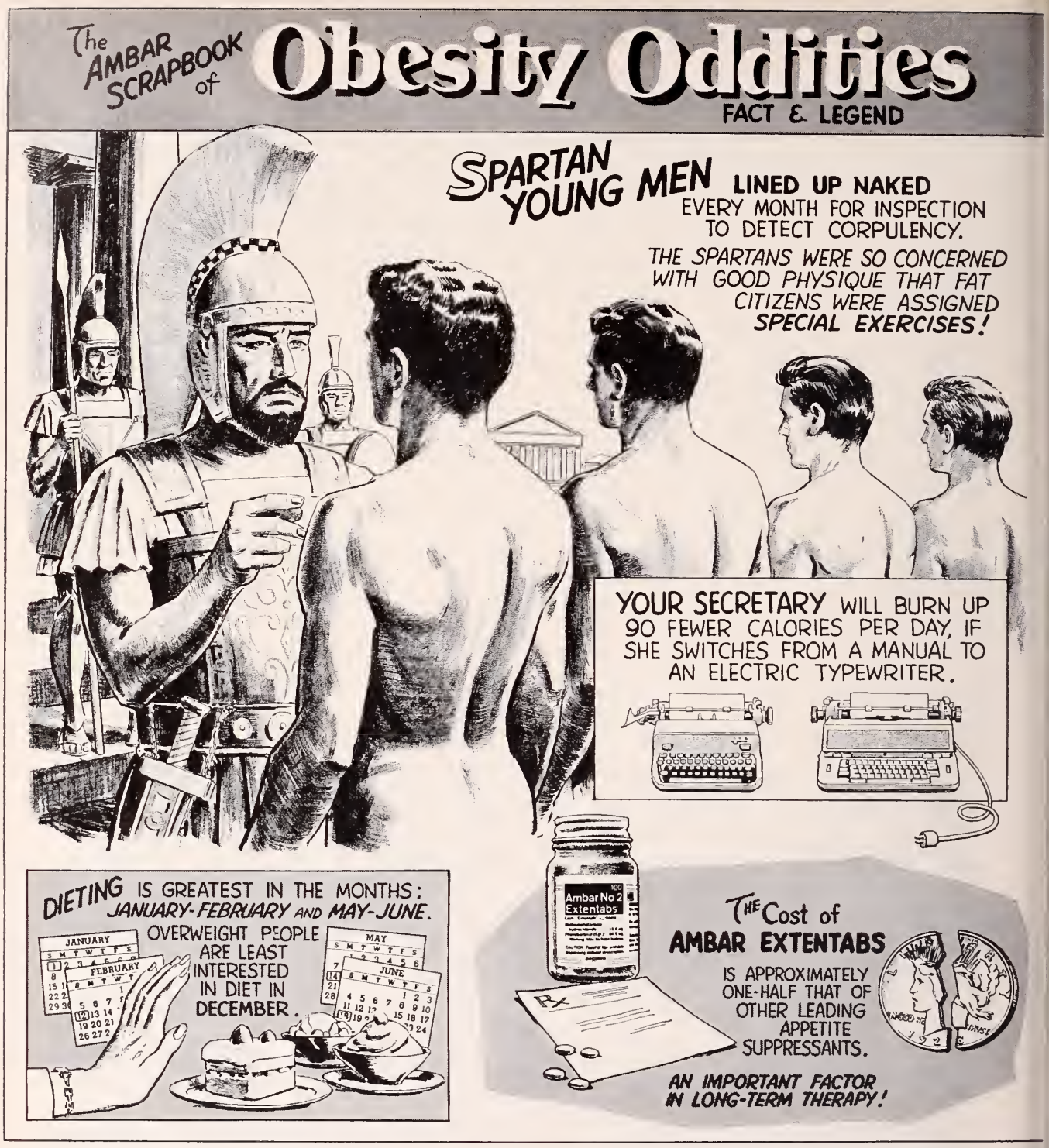
At the scientific session of the meeting Dr. J. Lawton Smith of Miami, Fla., spoke on "Recent Advances in Seronegative Ocular Syphilis." Following Doctor Smith's talk a clinical pathological conference was held. Dr. Guillermo B. deVenecia, ophthalmic pathologist at University Hospitals, Madison, presented a case of retinoblastoma and a case of diktyoma. These cases were discussed by Dr. Herbert Giller and Dr. Samuel Blankstein of Milwaukee. WILLIAM H. BENNETT, M. D., Secretary.

DR. SPARKS JOINS MARSHFIELD CLINIC

Dr. George M. Sparks joined the staff of the Marshfield Clinic in July. He completed his residency at the Illinois Eye and Ear Infirmary and has been serving in the U. S. Public Health Service assigned to the Wisconsin Division of Health.

WISCONSIN–UPPER MICHIGAN SOCIETY OF O–O

The next meeting of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology will be held at Maxwelton Braes Resort, Bailey's Harbor, Sept. 20–22. Physicians who are interested in becoming members of this society should write to George L. McCormick, M.D., Secretary, 102 East Main Street, Waukesha, Wis. 53186.



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Clinic Day, Waukesha Memorial Hospital

The subject of trauma was discussed at a one-day clinic program June 14 at the Waukesha Memorial Hospital. Principal speaker was Dr. Richard C. Lillehei, professor of surgery at the University of Minnesota Medical School and a pioneer in research on heart and pancreas transplants.

Other distinguished speakers included *Dr. Anthony R. Curreri*, chairman of the Department of Surgery, University of Wisconsin Medical School; Dr. Adrian E. Flatt, professor of orthopedic surgery, University of Iowa; *Dr. Miles B. Smith*, president, Milwaukee Gastroenterology Society; and *Dr. Joseph C. Darin*, assistant professor of surgery, Marquette School of Medicine, Milwaukee.

Hospital staff members presenting papers were *Drs. C. A. Desch, J. L. Barber, A. E. Kritter, R. S. Monk, M. Z. Fruchtman*, and *A. M. Richter*.

Wisconsin Heart Association Meeting

"An Interdisciplinary Approach: Key to a Successful Coronary Care Unit" was the topic of the scientific session of the Wisconsin Heart Association annual meeting, June 6, at the Pioneer Inn in Oshkosh.

Dr. James E. Crockett, and Miss Dona Gilbo, R.N., were the two main speakers for the session. Doctor Crockett is the director of the coronary care unit at St. Luke's Hospital in Kansas City, Mo. He is a fellow of the American College of Physicians and the American College of Cardiology.

Miss Gilbo is an instructor in medical nursing at the University of Wisconsin, Madison. She is also co-chairman of the coronary care subcommittee of the Wisconsin Regional Medical Program.

Dr. Richard H. Wasserburger, Madison, planned and coordinated the program for the scientific session. He is chief of cardiology at University Hospitals, Madison.

Dedicate Doctors Hospital Building

Dedication of the $8,000,000 Doctors Hospital building in Milwaukee was held May 15, in the new lobby.

Principal speaker was Dr. Madison B. Brown, Chicago, associate director of the American Hospital Association. His subject was "Winds of Change for Hospitals." Master of Ceremonies was Atty. Stewart G. Honeck, secretary of the Board of Trustees.

Brief remarks were also presented by Alfred Korbel, chairman of the Board of Trustees; *Dr. J. B. Wilets*, chief of staff, who accepted the new Doctors Hospital on behalf of the medical staff; and Walter G. Harden, administrator.

Mr. Honeck and Donald Key, MILWAUKEE JOURNAL art editor, participated with *Dr. Harold J. Dvorak*, who with his wife, *Dr. Laura Fisher Dvorak*, founded Doctors Hospital in 1947, in the unveiling of two oil paintings by Wisconsin artist Robert von Neumann. The world-famous artist's works, entitled "The Net Menders" and "The Fishermen" were donated to the hospital to honor the Board of Trustees.

Nursing School Starts Last Freshman Class

Capping exercises for 31 freshmen students at St. Francis Hospital School of Nursing (Class of 1970) were held May 19, at the school's auditorium. This marked the end of such freshmen capping ceremonies for the school as it is being phased out in favor of the newly created four-year program, leading to a Baccalaureate Degree in Nursing, instituted at Viterbo College, La Crosse. These freshmen students will graduate from the school in 1970, marking the 68th year of operation since its formal opening in 1902. Since its beginning, 1,875 nurses have graduated from St. Francis, wearing the school's traditional cap and pin.

New Administrator, St. Croixdale Hospital

Richard O. Zocher has been appointed Administrator of St. Croixdale Hospital Inc., in Prescott. Prior to his appointment, Mr. Zocher was associated with Mounds Park Hospital in St. Paul for eight years as business manager. He is a licensed hospital administrator and a graduate of Monroe High School and Globe Business College.

Pinning Ceremony, Marquette Nurse Alumnae

Rod Johnston, Milwaukee attorney, and a former assistant district attorney, was the principal speaker at the Pinning Ceremony of the Marquette University Nurses Alumnae Association May 31. His subject was "The New Aristocracy."

The ceremony, an annual event preceding graduation services for the university, was held in the auditorium of the College of Nursing on the campus for candidates for the degree of Bachelor of Science in Nursing.

Mr. Johnston challenged graduates with the fact that they, as members of the new aristocracy, must accept the prerequisite, responsibility. Historically, aristocracy was a matter of birth, with material wealth one of the qualifications; but today it is determined by intelligence, education, will and drive.

"The youth of the country has discovered that it can not only affect taste in dress, music, and entertainment," said Johnston, "but can also influence and direct the nation's policies.

"Responsibility must be assumed by this aristocracy of youth. No young person who wishes to have a share in the direction of his country can ignore

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the need for responsible action, nor be immune to the consequences of its lack."

Sister Mary Thomas, Dean of the Marquette University College of Nursing, awarded pins to the candidates for graduation. The pin signifies the graduate's membership in the American Nurses Association and also in the Marquette University Nurses Alumnae Association.

The ceremony was followed by a tea for about 400 parents, relatives and friends of the graduates.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF MAY 22, 1968

NEW MEMBERS

Belden, Allan D., 610 East Longview Dr., Appleton 54911
Bentley, John Dwight, 18 South Owen Dr., Madison 53705
Dettmann, Frederick G., 1416 South Commercial St., Neenah 54956
Di Raimondo, Joseph C., 2037 Floyd Place, Madison 53713
Harbour, Jeanne D., 301 Troy Dr., Madison 53704
Hirschler, Charles W., 20 South Park St., Madison 53715
Kinde, Robert R., 604 North Richmond, Appleton 54911
Mc Kenna, David H., 1821 South Webster Ave., Green Bay 54301
Miller, David, 4704 Wilson Rd., Kenosha 53140
Molina, Rodolfo, 207 South University Ave., Beaver Dam 53916
Schultz, James H., 1622 Chestnut St., P. O. Box 379, West Bend 53095
Stinchcomb, David E., 1300 University Ave., Madison 53706
Witt, Darrell L., 409 Spruce St., River Falls 54022

REINSTATED

Balzer, Rudolph R., 1410 North 27th St., Milwaukee 53208
Mills, E. Grady, 250 Buffalo St., Mondovi 54755

CHANGES OF ADDRESS

Agarwal, Avadh B., 1051 West Acacia Rd., Milwaukee 53217
Angus, D. C., 1403 Shirley St., Green Bay 54304
Baker, David J., 190 Gardner Ave., Burlington 53105
Benjamin, H. B., 6168 Washington Circle, Milwaukee 53213
Boulanger, Wayne J., 324 East Wisconsin Ave., Milwaukee 53202
Cromer, Robert W., 1111 Langlade Rd., Antigo 54409
Curran, William P., 1111 Langlade Rd., Antigo 54409
Daniells, Albert S., Route 1, Box 173, Black River Falls 54615
Denio, Martin J., Jr., Elm Grove, to P. O. Box 2883, West Allis 53219
Dortzbach, Richard K., Birmingham, Ala., to 730 Odana Lane, Madison 53711
Foregger, Richard, 6780 West Appleton Ave., Milwaukee 53216
Gander, E. Paul, 190 Gardner Ave., Burlington 53105
Garrity, John E., 1111 Langlade Rd., Antigo 54409
Goldstein, Paul H., 2040 West Wisconsin Ave., Milwaukee 53233
James, Richard L., Cudahy, to 617 Badger Ave., Milwaukee 53172
Konicek, Robert G., Tomah, to 1735 Third St., Northwest, Rochester, Minn. 55901
Knights, Curtis C., Madison, to 2734 West Calle Morado, Tucson, Ariz. 85705
Linn, John C., 2266 North Prospect Ave., Milwaukee 53202
Martens, Thomas J., Ft. Belvoir, Va., to U.S.A.R.V. Trans Det., A. P. O. San Francisco 96375, Calif.
Martens, William E., Milwaukee, to 11716 West Clarke St., Wauwatosa 53226
Massart, John J., Peru, Ind., to 9212 Hardin Blvd., Wauwatosa 53226
Morbeck, Floyd E., Milwaukee, to 1622 Chestnut St., West Bend 53095
Mc Bride, Frank F., Lemoore, Calif., to 95 Meadowbrook Blvd., Fond du Lac 54935
O'Leary, W. J., Jr., Franklin, to 1118 Silver Lane, La Crosse 54601
Olson, Marvin H., Schofield, to University Hospitals, 1300 University Ave., Madison 53706
Pellegrino, Ernest A., Jr., 715 Meadow Lane, Madison 53705
Pratt, Mary V., Monroe, to 1300 University Ave., Madison 53706
Schatz, Walter R., Racine, to P. O. Box 36, Ceres, Calif. 95307
Schrock, Joseph B., Sharon, to 100 South Washington St., Elkhorn 53121
Seay, Margaret J., Winnebago, to n/c Mrs. David Lippert, 1135 Elmwood Ave., Oshkosh 54901
Sickels, William F., Wilmington, Calif., to 240 Steven St., Neenah 54956
Tonkens, Samuel W., Wood, to 925 East Wells St., Milwaukee 53202
Truszkowski, Anthony, Glendale, to 5910 Ipswich Rd., Bethesda, Md. 20014
Vakilia, Hossein, Seattle, Wash., to 3600 Elizabeth, Lacey, Wash. 98501
Wenders, James A., 12100 West Verona Court, West Allis 53227
Wheaton, Robert C., 190 Gardner Ave., Burlington 53105
Wheeler, Robert M., 2119 Northeast 16th Ave., Fort Lauderdale, Fla. 33305
Wilkinson, Donald C., 530 West Wisconsin Ave., Oconomowoc 53066
Wilkinson, John J., 2520 South 91st St., West Allis 53227

NOTE OF EXPLANATION

It was reported in the April issue that Dr. Howard A. Winkler had been removed from the membership role. Doctor Winkler was a loyal and faithful member of the State Medical Society of Wisconsin and the Columbia–Marquette–Adams County Medical Society from 1947 until 1962 while practicing in Pardeeville.

In June 1962, Doctor Winkler moved to Denver, Colo., to take a residency in psychiatry at the University of Colorado. During the next five years he remained a resident member of the State Medical Society, the maximum time allowed for this type of membership. In the meantime, Doctor Winkler had become a member of the Denver County Medical Society and the Colorado State Medical Society, but this information for transfer of membership had not reached the State Medical Society at the time that his membership classification had terminated.

SOCIETY RECORDS *continued*

REMOVED FROM MEMBERSHIP

Baldwin, Elizabeth, Wood County, removed per County Secretary
Friend, Charles R., Wood County, removed per County Secretary
Greenfield, Bruce E., Rock County, resigned
Jarvis, Donald F., Lincoln County, resigned
Kappus, Harold C., Kenosha County, removed per County Secretary
Leach, John E., Racine County, resigned
Marks, Charles, Milwaukee County, transferred to Ohio
Mc Master, John E., Dane County, transferred to Pennsylvania
Organick, Avrum B., Milwaukee County, transferred to Colorado
Sattler, James R., Wood County, transferred to Illinois
Zimmerman, Lois, Trempealeau–Jackson–Buffalo County, resigned

DEATHS

Martens, Earl W., Milwaukee County, Apr. 8, 1968
Lewis, Charles N., non-member, Apr. 19, 1968
Kinsman, Frank C., Eau Claire–Dunn–Pepin, Apr. 20, 1968
Malin, George F., non-member, Apr. 22, 1968
Shewalter, G. M., non-member, Apr. 27, 1968

HIGH BLOOD PRESSURE SYMPOSIUM PROCEEDINGS

The proceedings of the Symposium on Objective Recording of Blood Pressure sponsored by the American Heart Association, United States Public Health Service, and the Chicago Heart Association are now available. Copies can be obtained through the Wisconsin Heart Association, 205 W. Highland Ave., Milwaukee, Wis. 53203, at $4.50 each.

The purpose of the symposium was three-fold: (1) to bring the scientific community up to date on the state of the art of objective recording of blood pressure; (2) to develop a dialogue among the scientists working in this area as well as medical and industrial people; and (3) to elicit recommendations which would stimulate the needed research and development.

The proceedings will be of value to physicians and other scientists engaged in epidemiological investigations involving blood pressure measurements to physicians and hospital administrators concerned with blood pressure monitoring, and to the individual physician interested in monitoring the blood pressure of an ambulatory patient placed on a hypotensive agent.

NEW EDUCATIONAL MATERIALS FROM YOUR HEART ASSOCIATION

Catecholamines in Cardiovascular Physiology and Disease (AHA Monograph Series No. 17), the proceedings of a conference held January 25–27, 1967, in Canberra, Australia, is now available from your Wisconsin Heart Association. The 250-page monograph, edited by Ralph Reader, Ph.D. (Oxon), can be purchased at $3.00 per volume.

The proceedings of the conference summarize the present knowledge in the field. Papers presented discuss the following topics: the uptake, storage and release of transmitter by nerve granules, the relationship between electrical processes and chemical transmission, the distribution of enzymes involved in catecholamine biosynthesis in sympathetic nerves, the relationship of catecholamine biosynthesis to the mechanism of hypertension, therapeutic procedures based on modification of catecholamine synthesis, the influence of catecholamines on the peripheral vasculature or on the myocardium and adrenergic effects on myocardial structure, metabolism and function.

Risk Factors and Coronary Disease—a statement for physicians, by an Ad Hoc committee of Epidemiologists and reviewed by the AHA Scientific Councils and major Medical Committees, summarizes for the practicing physician the current recommendations concerning education and management aimed at preventing or retarding the development of atherosclerosis and its complications. The different risk factors which have been identified are described, with designation of abnormal levels of certain factors.

Differential Diagnosis of Chest Pain, a 16mm, color film with sound, is now available on a loan basis from the Wisconsin Heart Association Film Library. The film emphasizes the importance of a complete patient history when determining the etiology of chest pain. Means for eliciting a meaningful history is emphasized by physician–patient interviews. Relevant physical examination procedures and the relationship of angina pectoris to atherosclerosis and ischemic heart disease are discussed. Angina symptoms are compared with those of "benign" causes of chest pain, both esophageal and musculoskeletal. The significance of resting ECG's, exercise ECG's and coronary arteriography in the diagnosis of chest pain is surveyed.

The film runs 25 minutes. It can be purchased from the Warner–Chilcott Labs, Audio-visual services; 201 Tabor Road; Morris Plains, New Jersey; 07950 at a cost of $125.00.

OBITUARIES

Dr. Orhan Bingol, 38, Walworth, died Apr. 26, 1968, in Park Ridge.

Doctor Bingol graduated from the Medical School of Ankara University, Turkey, in 1956. He served his internship at Augustana Hospital in Chicago and his residency at the Lutheran Deaconess Hospital, Chicago.

Doctor Bingol was secretary–treasurer of the Walworth County Medical Society, a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Jeannie, and three sons, Orhan, Jr., Tom, and Jon.

Dr. Willis J. Potts, 73, Sarasota, Fla., died May 5, 1968, in Sarasota.

Doctor Potts was born in Sheboygan and graduated from Rush Medical College in 1925. He served in the South Pacific during World War II. Doctor Potts, world renowned children's surgeon, developed the instruments and techniques that daily save newborn infants with heart defects.

Doctor Potts was the recipient of the American Medical Association gold medal, the distinguished service award of the University of Chicago Medical School, distinguished service medal of the American Heart Association, the University of Chicago alumni award, and the William E. Ladd medal of the American Academy of Pediatrics.

Surviving is his widow, two sons, and a daughter.

Dr. Campbell C. Edmondson, 73, Waukesha, died May 9, 1968, in Waukesha.

Doctor Edmondson graduated from the University of Tennessee Medical School in 1921 and practiced medicine in Waukesha until his retirement in 1964. He was the former chief-of-staff and chief of medicine at Waukesha Memorial Hospital where he served on the board for 10 years.

He was a former president of the Waukesha County Medical Society, a member of The State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Margaret; a daughter, Mrs. David (Margaret) Richards of Genesee Depot; and a son Robert C., of Woodland, Calif.

Dr. Arthur T. Holbrook, 97, Milwaukee, died May 22, 1968, in Milwaukee.

Doctor Holbrook graduated from Rush Medical College in 1895 and interned at the Presbyterian Hospital, Chicago. He was in the Wisconsin National Guard during the Spanish–American War. Doctor Holbrook retired in 1947 after 50 years of medical practice, and was affiliated with the Milwaukee Academy of Medicine, Milwaukee Surgical Society, and a fellow of the American College of Surgeons.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are three sons; Dr. Arthur A., Milwaukee, Herbert T., Woodside, Calif., and Matson of Wayne, Ill.

Dr. George P. Dernbach, 57, New London, died May 22, 1968, in New London.

Doctor Dernbach received his B.S. degree from St. Mary's College, Kansas, and graduated from the Marquette University School of Medicine, Milwaukee, in 1936, and took his internship and residency at Milwaukee County Hospital. He was a staff member of New London Community Hospital, Borchardt Memorial Hospital, and St. Joseph Residence.

Doctor Dernbach was a member of the Waupaca County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Dorothy; and a son, David, and a daughter, Candi.

Dr. Carl N. Neupert, 70, retired State Health Officer, died May 22, 1968, in Madison.

Doctor Neupert graduated from Washington University School of Medicine in 1925 and took his internship at Missouri Baptist Sanatorium in St. Louis and a residency in Pediatrics at Strong Memorial Hospital (University of Rochester) in New York. Doctor Neupert served with the United States Navy in World War I. He spent several years in private practice in Janesville before becoming supervisor of local health services for the State Board of Health in 1936. In 1938 he received his Master's degree in Public Health from Michigan State University. Doctor Neupert was appointed State Health Officer in 1943 and served until his retirement in 1965. In 1953, Doctor Neupert was appointed by the late Secretary of State John Foster Dulles, as a delegate to the Sixth World Health Assembly in Geneva, Switzerland. He was also health chairman of the National Congress of Parents and Teachers from 1950 to 1953, and a member of the National Education Association and American Medical Association Joint Committee on Health Problems in Education from 1949 to 1953, serving as chairman from 1952 to 1953. He was a diplomate of the American Board of Preventive Medicine and Public Health and a member of the United States Public Health Association. He was recipient of the McCormick Award from the United States Public Health Service. In 1965, the State Medical Society

Carl N. Neupert, M.D.

awarded Doctor Neupert the Council Award, its highest honor, and the State Senate passed a joint resolution honoring him for his 29 years of service to the state. (See also editorial in June 1968 issue at page 307.)

Doctor Neupert was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Melba; two sons, John, at home, and David, Milwaukee; and two grandchildren, Peter Scott and Suzanne.

* * *

BOOKLET: VD CONTROL PROBLEM

"Today's VD Control Problem," a 62-page joint statement, has been written and published by The American Social Health Association. Assisting with this activity were the co-sponsors, The American Public Health Association and The American Venereal Disease Association, in cooperation with the American Medical Association and The Association of State and Territorial Health Officers.

"The Joint Statement, now in its 15th year, is made possible by the response of state and local health officers each year to a comprehensive questionnaire about VD control problems in their areas of jurisdiction; by the cooperation of the Venereal Disease Program of the Public Health Service in supplying state and national statistics; and by the World Health Organization for information about VD around the world," states the publication. At the present time, the questionnaire for next year's joint statement is being reviewed.

Complimentary copies of this manual have been mailed to state and county medical societies.

Others interested in obtaining a copy of this timely publication may do so by sending $1.00 to the American Social Health Association, 1740 Broadway, New York, New York 10019. Special prices are available on quantity orders.

Both the AMA's Department of Environmental Health and the Council on Environmental and Public Health have played a vital role in the production of this booklet. However, the AMA and The Association of State and Territorial Health Officers have chosen to participate in this project in a cooperative capacity as opposed to the capacity of a sponsor. One important reason is the enactment of Public Law 89–479, *Comprehensive Health Planning and Public Health Service Amendments of 1966.* With its passage, "and the recent reorganization of the Public Health Service, there will no longer be a specific appropriation for aid to states and localities for venereal disease control."

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison, Wisconsin 53701.

Interprofessional Code
An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

Guide to The Service Corporation Law
A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

Code of Necropsy Procedure
A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

Hearing Conservation Programs for Wisconsin Industries
Some recommended standards and principles for providing a hearing conservation program in industry.

Occupational Health, A Guide for Medical and Nursing Personnel
General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.
New expanded edition—$5.00 with binding, $4.00 without binding. Ideal for any industrial plant with nurse service.

Find Your Future in the Health Field
A career guide (the health careers brochure).

Guide to Immunization Planning
An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

Inspection of Medical Records
An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

Principles for Transporting the Ill and Injured
A guide for providing emergency transportation services, including model community and state ordinances.

School Vision Screening Program
An outline to facilitate the development of a program to detect significant visual defects among school children.

First Aid Chart

Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959
Relating to fee splitting between physicians and others.

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195. COUMARIN AND THE ANTICOAGULANTS AND MANAGEMENT OF TOXICITY
Ovid Meyer, M.D., Madison

196. ULCERATIVE COLITIS
Harry Kanin, M.D., Milwaukee

197. MENTAL PATIENT, Procedure for Commitment
Leigh Roberts, M.D., Madison

198. HAY FEVER, Office Treatment of
John Arkins, M.D., Milwaukee

199. ASTHMA, Problems of Aerosol Treatment
John Arkins, M.D., Milwaukee

200. STROKE, Diagnostic Procedures and Indications for Carotid Endarterectomy
Manucher Javid, M.D., Madison

201. RHEUMATOID ARTHRITIS, ACUTE, Management of
Mark Mueller, M.D., Madison

202. RHEUMATOID ARTHRITIS, CHRONIC, Management of
Mark Mueller, M.D., Madison

203. DISACCHARIDE INTOLERANCE
James Manier, M.D., Marshfield

204. ULCERATIVE COLITIS, Medical Treatment of
James Manier, M.D., Marshfield

205. G. I. BLEEDING, ACUTE, Therapy of
James Manier, M.D., Marshfield

206. LYMPHOMA, Diagnostic Measures in
Donald Korst, M.D., Madison

207. LYMPHOMA AND LEUKEMIA, Investigational Drugs in
Donald Korst, M.D., Madison

208. THYROID HORMONES, Use of
Edwin Albright, M.D., Madison

209. THE RED EYE
James Allen, M.D., Madison

210. ELECTIVE CARDIOVERSION: Pros and Cons
A. J. Richtsmeier, M.D., Madison

211. DRUG ABUSE BY TEENAGERS
J. C. Westman, M.D., Madison

212. LOSS OF VISION, Patient Who Complains of
Frank Myers, M.D., Madison

213. DIGITALIS, Pharmacological Action of
Leon Goldberg, M.D., Atlanta

214. CHOLESTEROL LOWERING AGENTS, Current Status of
David Kritchevsky, M.D., Philadelphia

215. EXPERIMENTAL ATHEROSCLEROSIS
David Kritchevsky, M.D., Philadelphia

216. CATECHOLAMINES AS CARDIOTONICS
Steven Wolfson, M.D., Boston

217. PROPRANOLOL: Uses and Contraindications
Steven Wolfson, M.D., Boston

218. DIURETIC THERAPY, Today's Problems
Arthur Bernstein, M.D., Newark

219. DIURETICS, THIAZIDE, Untoward Effects
Albert Brest, M.D., Philadelphia

220. RUPTURED MEMBRANES, Prolonged, Management of the Newborn
Thomas K. Oliver, M.D., Seattle

221. INTRA-UTERINE GROWTH RETARDATION
Frederick C. Battaglia, M.D., Denver

222. MIDDLE EAR EFFUSION
Paschal A. Sciarra, M.D., Sheboygan

223. CANCER OF THE LARYNX, Cigarettes and
Paschal A. Sciarra, M.D., Sheboygan

224. SCUBA DIVING, Medical Phase of
John R. Evrard, M.D., Milwaukee

225. HERNIATED INTERVERTEBRAL DISC
Sanford Larson, M.D., Milwaukee

226. CAROTID, Cavernous Fistula
Sanford Larson, M.D., Milwaukee

227. RENAL FAILURE, CHRONIC, Management of
Richard Rieselbach, M.D., Madison

228. HYPERTENSION—PROGNOSIS, Treated and Untreated
John H. Moyer, M.D., Philadelphia

229. HYPERTENSION AND ANTIHYPERTENSIVE AGENTS
John H. Moyer, M.D., Philadelphia

230. BELL'S PALSY, Early Treatment of
Watson B. Larkin, M.D., Eau Claire

231. OTITIS MEDIA, SECRETORY, IN CHILDREN, Diagnosis and Treatment of
Watson B. Larkin, M.D., Eau Claire

232. ABDOMINAL AORTA, Aneurysm of
Victor Bernhard, M.D., Milwaukee

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Victor Bernhard, M.D., Milwaukee

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Victor Bernhard, M.D., Milwaukee

235. CHROMOSONE STUDIES, Indications for
Frank Walker, M.D., Milwaukee

236. UPPER RESPIRATORY INFECTIONS IN CHILDREN
June Osborn, M.D., Madison

237. LOWER RESPIRATORY INFECTIONS IN CHILDREN
June Osborn, M.D., Madison

238. PERIRECTAL ABSCESS AND FISTULAE
Gordon Marlow, M.D., Madison

239. RECTAL POLYPS, Diagnosis and Treatment of
Gordon Marlow, M.D., Madison

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June Osborn, M.D., Madison

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

PATHOLOGY

Volumes 1 and 2, fifth edition. Edited by W. A. D. Anderson, M.A., M.D., F.A.C.P., F.C.A.P., professor of pathology and chairman of pathology department, University of Miami School of Medicine, and director of pathology laboratories, Jackson Memorial Hospital, Miami. C. V. Mosby Co., St. Louis. 1966. 1,439 pages. Price: $21.

This well known text has been thoroughly revised and updated. It will be of interest to see how practical the separation into two volumes will prove to be from the students' standpoint. This book has a long list of competent contributors whose efforts have been extremely well blended and amplified by the editor. This now standard, authoritative and widely used textbook of Pathology can be highly recommended for medical students, residents in Pathology and other specialties as well as a reference for those physicians who attempt to keep updated with the rapid advances in the medical sciences.

MODERN HOME REMEDIES

And How to Use Them. By Morris Fishbein, M.D., editor of MEDICAL WORLD NEWS and WORLD WIDE ABSTRACTS OF GENERAL MEDICINE. Doubleday & Co. Inc., Garden City, N.Y. 1966. 129 pages. Price: $3.95.

This small volume contains much useful information for lay readers. Doctor Fishbein recognizes the reality of self-treatment, and the book is written to provide some guidance for such treatment. In each of the areas covered, he gives appropriate suggestions and instills a note of caution.

Pain-relievers, sedatives, diet foods and pills, antacids, and vitamins are discussed, as well as such topics as headache, sleeplessness, constipation, the common cold, and hemorrhoids. The book is written in a straight-forward way that will appeal to many. Readers will appreciate the author's use of humor.

There was some repetition in the book. As interesting as these facts are, it hardly seems necessary to state twice that there are at least eighty different viruses associated with the common cold, nor to give the content of APCs more than once. The space might better have been used to place greater emphasis on precautions and hazards of self-medication.

The title of the book may be a little misleading. The author discusses those remedies used at home not usually prescribed by a physician, but to potential readers the title may suggest bread poultices or sassafrass tea.

The content is practical, appropriate, and sound. This book would make a useful addition to every doctor's waiting room—SIGNE S. COOPER, R.N.

PEDIATRIC THERAPY

Edited by Harry C. Shirkey, M.D., F.A.A.P., director, Children's Hospital of Birmingham, Ala.; associate professor of pediatrics, Medical College of Alabama, Birmingham; professor and chairman, department of pharmacology, Howard College, Birmingham. Second edition. C. V. Mosby Co., St. Louis. 1966. 1223 pages. Price: $18.50.

This book is made up of 107 chapters contributed by 84 recognized authorities. The emphasis in Pediatric therapy is on treatment and not on diagnosis.

The first section deals with the fundamentals in drug treatment. General principles and supportive care are outlined which are of some practical importance to the practicing physician.

The section covering care of the newborn infant is partially complete, especially regarding care of the premature. Points about temperature control and early feeding were not forcefully stressed.

I was disappointed in the section concerning infectious disease. The choice of antibiotics and diagnostic steps in osteomyelitis were in conflict with the recent literature. The treatment of bacterial meningitis was similarly out of date. Ampicillin in the treatment of bacterial meningitis was not mentioned.

Hemolytic disease of the newborn and hyperbilirubinemia were incompletely attacked. Little attention was paid to diagnostic procedures. Nothing was mentioned concerning albumin binding, blood pH, and hypoxia which may affect bilirubin binding.

I was also unimpressed with the section about renal disease. The chapter on glomerulonephritis was incomplete as was treatment of bacterial infection of the GU tract.

The chapter on poisoning was concise and easily readable. The table listing the common poisons, their symptoms and treatment along with a table of drug dosages would make this a welcome addition to the general physician's library. General principles of therapy are outlined with the complete care of the ill child stressed.—LESTER MANN, M.D.

* * *

TUMORS OF THE MAJOR SALIVARY GLANDS—A newly released American Cancer Society film for physicians and medical students. This 16 minute film illustrates the differential diagnosis and management of tumors of the major salivary glands: parotid, submaxillary and sublingual—and covers the indications and contraindications for biopsy, principles of surgery and results of treatment. To see this film, call your local ACS office.

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Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 67, No. 8 AUGUST 1968

SCIENTIFIC ARTICLES

Thymoma: Diagnostic and Therapeutic Aspects, by Robert B. Skor, M.D., Walter H. Jaeschke, M.D. and Halvor Vermund, M.D., Ph.D., Madison ---- 361

Evisceration of Bowel Through the Vagina Following Irradiation for Cervical Carcinoma; report of first known case, by Edgar A. Habeck, M.D. and Leo M. Peters, M.D., Milwaukee ---- 374

Intravenous Lidocaine Anesthesia in Surgery of the Extremities; report of fifty cases, by Donald M. Levy, M.D. and Detterick Bauer, M.D., Milwaukee ---- 375

Hereditary Hematuria, by William Maurer, M.D., Richard D. Fritz, M.D. and Frederick W. Madison, M.D., Milwaukee ---- 378

Therapeutic Dilemmas: Estrogens from Cradle to Grave (No. 10 of a Series), by Harry Beckman, M.D., Milwaukee ---- 382

Comments on Treatment: Management of Acne Vulgaris, by Derek J. Cripps, M.D., Madison ---- 387

SPECIAL FEATURES

Occupational Hearing Loss: Recent Trends and Practices (abstract) ---- 373

Paraben Sensitivity: Subtle Trouble (abstract) 377

First-Year Results of a Wisconsin Infant Immunization Survey, by H. Grant Skinner, M.D., M.P.H. and William L. Gilbert, B.Sc., Madison ---- 381

A Study of Disposable Surgical Masks (abstract) ---- 386

Morphological Investigation of Human Breast Cancer (abstract) ---- 386

Medical Memo: Museum of Medical Progress and Stovall Hall of Health ---- 26

New Listing Toll-Free Medical Tape Lectures 8

Tentative Schedule—Orthopedic Field Clinics 45

EDITORIALS

President's Page: A Daily Opportunity to "Set the Record Straight," by W. D. James, M.D., Oconomowoc ---- 397

Traduction of the Clinical Laboratory ---- 398

REGULAR FEATURES

Publication Information ---- 6

Medical Meetings ---- 7

Medical Green Sheet ---- 389

Letters ---- 400

The Medical Student Forum ---- 402

State Medical Society ---- 27

Physician News ---- 31

County Societies ---- 35

Specialty Societies ---- 37

Section on Ophthalmology ---- 39

Paramedical/Ancillary ---- 41

Obituaries ---- 43

Bookshelf ---- 45

Index to Advertisers ---- 50

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Journal
Established 1903

Annual Subscription ---- $10.00
Single Copy ---- 1.50
Previous Years' ---- 3.00
January Blue Book ---- 5.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago, Illinois 60610; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin 54481.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.

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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 WISCONSIN

Sept. 3–4: Governor's Conference for Home and Family, Milwaukee Technical College, Milwaukee.

Sept. 12–14: Fall meeting, Wisconsin Society of Internal Medicine, Oshkosh, at The Pioneer.

Sept. 14–15 (tentative): Fall meeting, Wisconsin Otolaryngological Society.

Sept. 14–15: Fall meeting, Wisconsin Society of Anesthesiologists, Lake Geneva, at the Playboy Club.

Sept. 17: Adolescent Symposium, Marshfield Clinic, Marshfield.

Sept. 20–22: Fall meeting, Wisconsin Radiological Society, Lake Geneva, at the Playboy Club.

Sept. 21: Fall meeting, Wisconsin Surgical Society, St. Mary's Hospital, Madison.

Sept. 25: 1968 Wisconsin Heart Association–Adolf Gundersen Medical Foundation Symposium on Hypertension, Wisconsin State University at La Crosse.

Sept. 25–26: Annual meeting, Wisconsin Academy of General Practice, Pfister Hotel, Milwaukee.

Oct. 1–4: Sixth annual Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Oct. 2: Pulmonary Thromboembolism Conference, sponsored by The Wisconsin Regional Medical Program, Coffey Auditorium, Milwaukee County Hospital, Milwaukee.

Oct. 3: Pulmonary Thromboembolism Conference, sponsored by The Wisconsin Regional Medical Program, Employers Insurance Company of Wausau, Wausau.

Oct. 5: 14th Annual Fall Cancer Conference (The Cancer Scrimmage), University of Wisconsin Medical Center, Madison.

Oct. 8–11: Meeting of the Wisconsin Nurses Association, Sheraton–Schroeder Hotel, Milwaukee.

Oct. 9–10: Meeting of Wisconsin Division, American Cancer Society, Oshkosh.

Nov. 16: Fall annual meeting of Wisconsin Society of Pathologists, Marquette School of Medicine, Milwaukee.

1968 NEIGHBORING STATES

Sept. 23–Oct. 4: PG course in Laryngology and Bronchoesophagology, Department of Otolaryngology of the Illinois Eye and Ear Infirmary and College of Medicine of the University of Illinois at the Medical Center, Chicago.

Sept. 26–29: "The Metabolic Basis of Heart Disease," American College of Physicians, Wayne State University School of Medicine, Detroit, Mich.

Oct. 12–18: Annual Otolaryngologic Assembly of 1968, Illinois Eye and Ear Infirmary at the Medical Center, Chicago, Ill.

Oct. 19–24: Annual meeting, American Academy of Pediatrics, Palmer House Hotel, Chicago, Ill.

Oct. 28–30: Clinical Reviews, Mayo Clinic and Mayo Foundation, Rochester, Minn.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

Nov. 11–13: Clinical Reviews, Mayo Clinic and Mayo Foundation, Rochester, Minn.

1968 OTHERS

Sept. 7–11: Second International Congress of the Transplantation Society, Americana Hotel, New York City.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo.

Sept. 25: "The Coronary Care Unit—Acute Myocardial Infarction," American College of Cardiology, St. Vincent's Hospital and Medical Center of New York, New York, N.Y.

Sept. 26–29: "The Metabolic Basis of Heart Disease," American College of Physicians, Wayne State University School of Medicine, Detroit, Mich.

Sept. 28–Oct. 3: Western Hemisphere Congress, International College of Surgeons, Honolulu, Hawaii.

Oct. 4–8: Tenth International Congress on Diseases of the Chest, American College of Chest Physicians, Washington Hilton Hotel, Washington, D.C.

Oct. 6–11: XVI Biennial International Congress, International College of Surgeons, Tokyo, Japan.

Oct. 7–12: "Stress and Disease—The Relationship of Psychologic and Social Forces in Pathogenic Mechanisms, American College of Physicians, University of Oklahoma Medical Center, Oklahoma City, Okla.

Oct. 9–11: 15th Western Cardiac Conference, University of Colorado Medical Center, Denver, and Colorado Heart Association.

Oct. 15–18: 51st Annual Meeting, American Dietetic Association, San Francisco, Calif.

Oct. 16–26: Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, International College of Surgeons.

Oct. 21–25: "Current Concepts of Neurology—Diagnosis and Treatment," American College of Physicians, University of Maryland School of Medicine, Baltimore, Md.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

Oct. 26–Nov. 11: Around-the-World Postgraduate Clinics, International College of Surgeons, India, Egypt, Holy Land, Israel, and Greece.

Oct. 27–28: Annual Leadership Conference, American Social Health Association, Hotel Biltmore, New York, N.Y.

Oct. 28–Nov. 1: "Rheumatic Diseases—Pathology Diagnosis and Treatment, American College of Physicians, Harvard Medical School (Robert B. Brigham Hospital), Boston, Mass.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

Oct. 31–Nov. 1–2: Annual course in Postgraduate Gastroenterology, American College of Gastroenterology, Statler Hilton, Boston, Mass.

Nov. 7–9: Second Annual Postgraduate Conference on "Today's Hospital Problems: An Interdisciplinary Approach," Mound Park Hospital Foundation with joint sponsorship of the University of Florida's J. Hillis Miller Health Center, The Tides Hotel and Bath Club, Redington Beach, Fla.

Nov. 11–14: Interstate Postgraduate Medical Association Assembly, Pittsburgh, Pa.

Nov. 11–15: "Cancer and Internal Medicine," American College of Physicians, Memorial Hospital for Cancer and Allied Diseases, New York, N.Y.

Nov. 13–16: Forty-seventh annual convention, National Easter Seal Society for Crippled Children and Adults, Sheraton-Boston Hotel, Boston, Mass.

Nov. 19–20: 22nd Annual Meeting, American Heart Association Council on Arteriosclerosis, Bal Harbour, Fla.

Nov. 20–22: Sixtieth annual conference, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

NEW TAPE LECTURES

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159. (re-issued) TRANQUILIZERS, Side Effects and Contraindications
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238. PERIRECTAL ABSCESS AND FISTULAE
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MEDICAL MEETINGS *continued*

Nov. 21–24: 41st Scientific Sessions, American Heart Association, Bal Harbour, Fla.

Nov. 22–23: Psychedelic Drugs meeting, The Hahnemann Medical College and Hospital of Philadelphia, Pa.

Nov. 25–26: Annual Assembly Meeting, American Heart Association, Bal Harbour, Fla.

Nov. 25–26: Meeting, American Society of Nephrology, Shoreham Hotel, Washington, D.C.

Dec. 2–6: "Physical Methodology in Medical Research," American College of Physicians, Massachusetts Institute of Technology, Cambridge, Mass.

Dec. 10–13: "Cardiology—1968," Institute for Cardiopulmonary Diseases of Scripps Clinica dn Research Foundation, American College of Cardiology, La Jolla, Calif.

Dec. 13–15: "Advances in Coronary Artery Disease," American College of Cardiology, Waldorf–Astoria Hotel, New York, N.Y.

1968 AMA

Oct. 5–6: Second National Congress on Medical Ethics, Judicial Council of the AMA, Drake Hotel, Chicago, Ill.

Dec. 1: Tenth National Conference on the Medical Aspects of Sports, AMA, Hotel Deauville, Miami Beach, Fla.

Dec. 1–4: Clinical Convention, AMA, Miami Beach, Fla.

1969 NEIGHBORING STATES

April 20–25: 50th Annual Session, American College of Physicians, Conrad Hilton Hotel, Chicago, Ill.

Apr. 30–May 4: M.A.C. VI-Midwest Anesthesiology Conference, Illinois Society of Anesthesiologists, Palmer House, Chicago.

1969 OTHERS

Jan.: AHA Council on Clinical Cardiology—"Cardiopulmonary Physiology," San Francisco, Calif.

Apr.: AHA Council on Clinical Cardiology—"Clinical Electrocardiography and Vectorcardiography," Augusta Ga.

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

June: AHA Council on Clinical Cardiology, title and location to be announced.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Winter: AHA Council on Clinical Cardiology—"Clinical Use of Cardiovascular Drugs," La Jolla, Calif.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Fall Cancer Conference at Madison

Dr. Paul C. Bucy, chairman of the department of neurosurgery at Northwestern University, will be the guest lecturer at the 14th annual fall cancer conference at the University of Wisconsin Medical Center in Madison Oct. 5.

Doctor Bucy will discuss "Tumor Metastases to the Central Nervous System." Dr. R. J. Samp, coordinator of the conference, said this is the first time that a lecture has been given on that subject since these conferences began.

The conference, co-sponsored by the UW division of clinical oncology and the American Cancer Society, Wisconsin Division, also will feature a variety of tumor reports and papers representing many fields of study.

Interested Wisconsin physicians may contact Doctor Samp at University Hospitals for information and application blanks.

Doctor Bucy will be the Helen Halverson visiting professor of neurosurgery at the Wisconsin Medical School Sept. 29–Oct. 5.

Gundersen Symposium on Hypertension

The 1968 annual symposium of the Adolf Gundersen Medical Foundation and Wisconsin Heart Association will be held Wednesday, Sept. 25, at the Wisconsin State University in La Crosse. There will be morning and afternoon sessions (9:30 am to 12:30 pm and 2:30 pm to 4:00 pm) with individual papers being given in the morning session and a panel discussion in the afternoon.

The subject of this year's symposium is Hypertension. Medical speakers and panel members of this symposium are:

COLIN DOLLERY, MD—Lecturer in Clinical Therapeutics, Postgraduate Medical School and Consultant Physician to Hammersmith Hospital in London, England—"Advances in the Treatment of Hypertension."

LEON I. GOLDBERG, MD—Professor of Medicine and Pharmacology, Emory University School of Medicine, Atlanta, Ga.—"Treatment in Essential Hypertension."

THEODORE L. GOODFRIEND, MD—Assistant Professor of Medicine and Pharmacology, University of Wisconsin, Madison, Wis.—"Cellular Aspects of Hypertension."

JOSEPH J. KAUFMAN, MD—Professor of Surgery, Urology, University of California, Los Angeles.—"Advances in the Diagnosis and Treatment of Hypertension of Renal Cause."

DAVID R. ROVNER, MD—Associate Professor in Internal Medicine, Division of Endocrinology and Metabolism, University of Michigan, Ann Arbor—"Adrenal Hypertension."

All physicians are invited to attend. Registration fee is $5 and advance registration is requested. For further information: A Erik Gundersen, MD, Program Chairman, Adolf Gundersen Medical Foundation, La Crosse, Wis.

Interstate Postgraduate Medical Assembly

The 53rd annual scientific assembly of the Interstate Postgraduate Medical Association will be Nov. 11–14 at the Pittsburgh Hilton Hotel in Pittsburgh, Pa. This teaching program is of special interest to the family physician. Social activities include a boat ride, style show, and an art-flower tour.

Speakers include Drs. Edward A. Banner, Rochester, Minn., Boris Senior, Boston, Mass.; Robert M. Zollinger, Columbus, Ohio; Kaye H. Kilburn,

SYMPOSIUM

"Controversies in the Diagnosis and Treatment of Stroke"

Thursday, September 19

PFISTER HOTEL & TOWER, MILWAUKEE

MORNING PROGRAM

Registration—8:30 to 9:15

9:15 WELCOME: *R. Clarke Danforth, MD,* Chairman, Stroke Committee, Wisconsin Heart Association

9:30 INTRODUCTION: Definition of the Problem: *Joseph M. Foley, MD,* Professor and Chairman, Division of Neurology, University Hospitals, Case Western Reserve University School of Medicine, Cleveland

10:00 DIAGNOSTIC METHODOLOGY AND PRINCIPLES OF CEREBRAL CIRCULATION: *William S. Fields, MD,* Professor of Neurology, University of Texas, Southwestern Medical School, Dallas

10:45 PRINCIPLES OF MEDICAL THERAPY: *Mark Dyken, MD,* Associate Professor of Neurology, Department of Neurology, Indiana University Medical Center, Indianapolis

11:15 PANEL DISCUSSION: Questions from the audience . . . *Philip T. White, MD,* Moderator

12:15 LUNCH: Imperial Ballroom

AFTERNOON PROGRAM

Chairman: *Victor M. Bernhard, MD*

1:45 REVIEW OF THE TREATMENT OF STROKE IN THE MARQUETTE SCHOOL OF MEDICINE, DIVISION OF SURGERY: *John J. Finneran, MD,* Resident in Surgery DISCUSSION

2:15 PRINCIPLES OF SURGICAL THERAPY: *Edwin J. Wylie, MD,* Professor of Surgery, University of California, San Francisco Medical Center, School of Medicine, Department of Surgery

2:40 SURGERY IN THE ACUTE STROKE: *Jesse E. Thompson, MD,* Associate Professor of Surgery, Southwestern Medical School, Dallas

3:15 PANEL DISCUSSION AND QUESTION PERIOD . . . *Philip T. White, MD,* Moderator

Program acceptable for six elective hours by the AAGP

Sponsored by

Wisconsin Heart Association Stroke Committee, Wisconsin Regional Medical Program, The Johnson Foundation and Marquette School of Medicine

Durham, N. C.; Edward H. Rynearson, Rochester, Minn.; H. Hoyle Campbell, Toronto, Ontario; James Leonard, Donald Leon, and James Shaver, Pittsburgh; Charles R. Shuman, Philadelphia; T. S. Danowski, Pittsburgh;

Sean Mullan, Chicago; Dwight C. Hanna, III, Pittsburgh; Leon I. Goldberg, Atlanta, Ga.; E. S. Gordon, Madison, Wis.; Leonard L. Lovshin, Cleveland, Ohio; Herbert D. Adams, Boston, Mass.; Vinton E. Siler, Cincinnati, Ohio; Edward T. Bowe, New York City; Alton Ochsner, New Orleans, La.; and William H. Masters, St. Louis, Mo.

Also on the program are Norman Robertson, vice-president and economist of Mellon National Bank and Trust Co., Pittsburgh, whose subject is "Inflation Forever?"; and Virginia E. Johnson of St. Louis, Mo., and Doctor Masters will lecture on "Facts and Fallacies of Human Sexual Response."

The program is acceptable for 23 elective hours by the American Academy of General Practice. Further details: Interstate Postgraduate Medical Association, 333 North Randall Avenue, Madison, Wis. 53706.

American Social Health Association

A national leadership conference, sponsored by the American Social Health Association, on venereal disease research priorities; biologic, behavioral, and control, will be held Oct. 27–28 at the Biltmore Hotel in New York City.

A major address will be given by A. J. Dalzell–Ward, D.P.H., Medical Director of The Council for Health Education, London, England. He will speak on "Britain's VD Education for High Risk Age and Cultural Groups."

Registration fee: $35. Contact: ASHA, 1740 Broadway, New York, N. Y. 10019.

Florida Postgraduate Conference

The Mound Park Hospital Foundation with the joint sponsorship of the University of Florida's J. Hillis Miller Health Center will conduct a postgraduate conference on "Today's Hospital Problems: An Interdisciplinary Approach," Nov. 7–9, at the Tides Hotel and Bath Club, Redington Beach, Fla.

This conference will be completely comprehensive and designed specifically for physicians who hold hospital staff leadership positions, hospital administrators, hospital trustees, and such allied personnel selected by hospital administration and division chiefs.

The program is acceptable for 18 accredited hours by the American Academy of General Practice. Registration fee: $75. Contact: M. A. Barton, M.D., President, Mound Park Hospital Foundation, 701—6th Street South, St. Petersburg, Fla. 33701.

Clinical Reviews, Mayo Clinic

The staff of the Mayo Clinic and the faculty of the Mayo Foundation, Rochester, Minn., are again presenting Clinical Reviews this year. Because of the large number attending in past years, there will be two identical sessions: Oct. 28–30 and Nov. 11–13.

The program is acceptable for credit by the American Academy of General Practice. Registration fee: $20. Contact: M. G. Brataas, Mayo Clinic, Rochester, Minn. 55901.

Congress on Occupational Health

The American Medical Association will conduct the 28th Congress on Occupational Health Sept. 30–Oct. 1 at the Waldorf–Astoria Hotel, New York City.

Representives of state and county medical society committees on occupational health will meet Saturday morning, Sept. 28, with the Council on Occupational Health of the AMA.

Dr. O. A. Sander of Milwaukee, private practitioner of occupational medicine, will give the final address Oct. 1 on "New Concepts of Employment in Tuberculosis."

Program is acceptable for 11 elective hours by the American Academy of General Practice. No registration fee.

Adolescent Symposium, Marshfield

An Adolescent Symposium will be presented Tuesday, Sept. 17, at the Marshfield Clinic in Marshfield. The symposium is approved for credit by the AAGP. Contact: Harold Fahs, ED.D., Chief Clinical Psychologist, Marshfield, Wis. 54449.

Family and Home Conference, Milwaukee

The second biennial Governor's Conference for Home and Family will be held Sept. 3 and 4 in Milwaukee at the Milwaukee Technical College, 1015 North Sixth Street, with an evening dinner at the Schlitz Clubhouse.

Purpose of the conference is to provide the citizenry of this state, both professional and nonprofessional, a common meeting ground, where the merits and goals of family unity and stability and improvements in family living patterns can be discussed, recommendations for action made and proposals for implementation of recommended programs begun.

Two physicians will be participating on the program: Dr. Andrew Watson, professor of both law and psychiatry, University of Michigan, who will speak on 'Lawyers and the Problems of Marital Reconciliation;" and Dr. Beverley Mead, professor and chairman, Department of Psychiatry, Creighton University, Omaha. She will discuss "What's Wrong With Marriage or Why Men and Women Don't Understand Each Other."

The $9.00 registration fee may be sent to the Council for Home and Family, 412 N., State Capitol, Madison, Wis. 53702.

Nicaragua Expresses Appreciation to Society for Its Assistance

Nicaraguan physicians expressed their gratitude to the State Medical Society of Wisconsin with presentation of a certificate of appreciation during a recent program of the Dane County Medical Society in Madison.

The certificate recognized the assistance of the Society in formation of a medical society in Nicaragua, Wisconsin's "sister state" under the Partners of the Alliance for Progress, a national program initiated originally by the late President John F. Kennedy and aided by a grant from the Agency for International Development.

Also recognized for his valuable help and guidance was Dr. Henry A. Peters, a Madison neurologist who is a member of the Governor's Committee on the Partners for Progress and the Society's representative to Nicaragua. Doctor Peters has visited the

A CERTIFICATE OF APPRECIATION was presented to the State Medical Society by representatives of the Wisconsin–Nicaragua Partners of the Alliance for Progress at a recent meeting of the Dane County Medical Society in Madison. Accepting the certificate are H. B. Maroney, assistant secretary of the State Medical Society of Wisconsin, and Dr. Henry A. Peters of the University of Wisconsin Medical School and a member of the Board of Directors of the Wisconsin–Nicaragua Partners of the Alliance for Progress, on the left. In the center is Edward Marcus, President of the National Association, Partners of the Alliance, Inc.; and on the right are Dr. Uriel Guevera, Dean of the Medical School of Nicaragua; and Dr. K. L. Siebecker, Jr., Chairman of the Department of Anesthesiology, University of Wisconsin Medical School.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY HOME DURING THE MONTH OF JULY 1968

2 Board of Trustees, Dane Co. Med. Soc.
8 Advisory Comm. on Extended Care Facilities, Dane Co. Med. Soc.
9 Stroke Study Committee, Wisconsin Regional Medical Program
10 Madison Society of OB–GYN
11 Board of Directors, Wisconsin Association of Professions
12 Subcommittee, Program Planning Committee for Annual Meeting, SMS
13 Section on Pathology, SMS
16–19 Professional Nurse Registration Examination
19–20 SMS Council and Commission on Medical Care Plans (Mackinac Island, Michigan)
23 Wisconsin Youth Comm., Program Planning for Wis. Work Week of Health
24 Central Wisconsin Pilot Study on Health Insurance
26 Open House, Museum of Medical Progress and Stovall Hall of Health (Prairie du Chien)
29 Insurance Advisory Comm., Dane County Medical Society

Meetings not held in the Society Home but which have a direct relationship are printed in italics, with the location in parentheses.

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Vitamin B_6	7.5 mg
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Latin American country on several occasions, individually and as a member of the Partners' special development team. Since 1965, when Doctor Peters first visited Nicaragua, Wisconsin has sent nearly $75,000 worth of used hospital and medical equipment to help Nicaraguan doctors improve the level of health care.

Partners of the Alliance is an organization through which civic clubs, labor unions, business and professional groups, and private individuals in the United States can work directly with similar Latin American groups demonstrating, by self-help, their determination to insure a better way of life.

The State Medical Society has given advice on how to set up programs for staffing hospitals, establishing guide lines for public health programs, organizing medical services, and developing health education activities, all of which are helping not only the Nicaraguan doctors but also the Nicaraguan people whom they serve.

AMA Convention Badges to Museum

At the request of the Wisconsin delegation to the American Medical Association's House of Delegates, which met in June at San Francisco, officers and delegates donated their convention badges for a special display at the Museum of Medical Progress at Prairie du Chien.

Dr. Gordon Scientific Medicine Chairman

At the June meeting of the Commission on Scientific Medicine, *Dr. Edgar S. Gordon* of Madison was elected chairman. At the same meeting *Dr. Jack A. Killins* of Green Bay was named general program chairman of the 1969 annual meeting of the State Medical Society.

Houghton Student Fund Continues to Grow

At the end of June the John H. Houghton, M.D. Medical Student Award fund totaled $5,824.50. The fund was established in early March by Dr. John H. Houghton who died March 25. The fund is being used to honor outstanding medical students from Wisconsin medical schools who show promise of becoming a "complete physician," an achievement Doctor Houghton stressed throughout his participation in Society affairs and particularly while president of the State Medical Society.

The first such awards were presented in May at the Society's annual meeting in Milwaukee. Recipients are James Renne of Kenosha, who graduated this spring from the University of Wisconsin Medical School in Madison and C. Robert Stanhope of Milwaukee, also a spring graduate of the Marquette School of Medicine in Milwaukee.

Contributions to this fund are being administered by the Society's Charitable, Educational and Scientific Foundation and may be sent to the Foundation, Box 1109, Madison, Wis. 53701.

AMA Honors Doctor Stovall

Dr. William D. Stovall of Madison was honored by the House of Delegates of the American Medical Association at its June annual meeting in San Francisco with a rising vote of thanks for 26 years as either a member of the House or member of the Council on Constitution and Bylaws.

New Racine City Health Officer

Dr. Gabriel P. Ferrazzano, who recently completed his 13th year with the U. S. Public Health Service, has been appointed Racine city health officer. Doctor Ferrazzano succeeds Dr. Albert C. Edwards who retired last year after 22 years as city health officer. Doctor Ferrazzano graduated from Marquette University School of Medicine in 1938 and interned at Waltham General Hospital, Mass.

UW Physicians Attend Meetings

Drs. Regene J. Nacheff and *Ruth A. Stoerker* of the University of Wisconsin Medical Center, Madison, attended the Third Biennial Scientific Meeting, California Society of Anesthesiologists, June 13–15, in Monterey, Calif.

Drs. Nancy Wu and Nalda Thung, of the Department of Anesthesiology, University of Wisconsin Medical Center, Madison, attended the AMA annual meeting in San Francisco June 16–20. They presented a scientific exhibit, "Effects of Anesthesia and Surgical Operations upon Respiratory Functions."

Exhibits at AMA Win Awards

Drs. Matthew D. Davis, Guillermo de Venecia, Ronal Engerman, Frank Meers, and Yvonne Magli of the University of Wisconsin Medical Center, Madison, presented a scientific exhibit at the AMA annual convention recently held in San Francisco. The exhibit, "Diabetic Retinopathy: A Clinical-Histopathologic Correlation," won a certificate of merit. "The Patterns of Porphyria" presented by Drs. Derek Cripps, *Sture A. M. Johnson,* and Arthur Daily of the dermatology department and *Dr. Henry Peters,* of neurology, won the certificate of merit for the dermatology section.

Dr. Blount Retires

Dr. Walter P. Blount, chairman of the orthopedic surgery department at Marquette School of Medicine, Milwaukee, recently retired and *Dr. Bruce J. Brewer* was named his successor. Doctor Blount had been department chairman since 1956 and a member of the faculty for 38 years. He twice received the gold medal of the American Academy of Orthopaedic Surgeons for his new techniques and was elected president of the Academy in 1954. He is also a past president of the Milwaukee Academy of Medicine.

Doctor Brewer, clinical professor of orthopedic surgery at Marquette, has been a member of the faculty since 1947. He has served on the sports medicine committee of the Academy of Orthopedic Surgeons and was an orthopedic consultant for the Milwaukee Braves.

DR. WALTER P. BLOUNT, who recently retired as chairman of the Marquette Department of Orthopedic Surgery, was presented a check for approximately $6,000 to be used for a research and education fund, now called the Blount fund, and formerly known as the Fuller Fund. Mrs. Arthur G. Kroos, Jr., whose late husband started the fund, made the presentation. Mrs. Kroos lives in Milwaukee. The $6,000 represents contributions to the fund given by the alumni group.

Dr. Falk Attends Writing Course

Dr. V. S. Falk, medical editor of the WISCONSIN MEDICAL JOURNAL, Edgerton, enrolled in a two-day course designed to assist and provide practical guidelines to physicians and others interested in medical writing and journalism at the University of California San Francisco Medical Center. The course was held following the American Medical Association's annual convention, June 16–20 in San Francisco, which Doctor Falk also attended.

Dr. Grand Retires

Dr. C. A. Grand, Ashland, recently retired from active practice. Doctor Grand graduated from the University of Minnesota School of Medicine and interned at St. Luke's Hospital, Duluth, Minn. He has served as president of the Ashland–Bayfield–Iron County Medical Society, president of the staff of St. Joseph's Hospital, Ashland General Hospital and Trinity Lutheran Hospital; president of the

Physicians whose names appear in italics are members of the State Medical Society.

Eleventh Councilor District of the State Medical Society, and presently serves as councilor for the Eleventh District. He has also served as a past president of the Wisconsin Academy of General Practice. He started the Heart Association of Wisconsin for Ashland–Bayfield–Iron Counties and is a past president of the Ashland County Cancer Society. Doctor Grand serves as a trustee for the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

Dr. Edson Joins Staff

Dr. Jack Edson recently joined the staff of the Albert A. Lorenz Institute in Eau Claire. He assumed the position of director and *Dr. Albert A. Lorenz* will remain on the staff as a consultant. Doctor Edson served as chief psychiatrist at Wisconsin School for Boys, Wales, for seven years; was a psychiatric consultant for the Milwaukee public school system and an instructor at the Marquette School of Medicine. He had been in private practice in Waukesha before joining the staff of the Institute.

Dr. Edwards New Lions President

At the regular meeting of the Richland Center Lions Club *Dr. Richard W. Edwards* of the Richland Medical Center was elected president for the year 1968–69.

Named to National Research Group

Dr. David T. Graham of the department of medicine, University of Wisconsin Medical Center, Madison, is the new president-elect of the Society for Psychophysiological Research. Dr. Frances K. Graham, pediatrics department, and Dr. Richard A. Sternbach, psychiatry, have been elected to the Society's Board of Directors.

Present Papers at AMA Meeting

Drs. Gene P. Wegner and *Timothy T. Flaherty* of the department of radiology, University of Wisconsin Medical Center, Madison, attended the AMA annual meeting June 16–20 in San Francisco. Doctor Wegner presented a paper on "Renal Vein Thrombosis: Radiologic Considerations," and Doctor Flaherty presented a paper on "Nonpenetrating Injuries to the Thoracic Aorta: Roentgen Considerations."

Dr. Maas Honored at "Appreciation Party"

Dr. David A. Maas, Webster physician for 50 years, recently was honored at an "appreciation party" by the residents of Webster, Danbury, and other Burnett County communities. Doctor Maas came to Burnett County in 1917 and in 1929 took over the practice of Dr. George Converse in Webster. He attended the Physicians and Surgeons College in Milwaukee and completed his medical training at the Chicago College of Medicine and Surgery. He and his wife have moved to Bozeman, Mont.

Dr. Carlsson Retires

Dr. Edward S. Carlsson, one of the original members of the Gundersen Clinic, La Crosse, recently retired from active practice. He joined the Gundersen Clinic in 1919 and is the sole survivor of the original clinic staff. Doctor Carlsson graduated from Rush Medical College in 1918. At the annual meeting of the State Medical Society in Milwaukee this spring, Doctor Carlsson was honored for his 50 years of membership in the Society.

Medical Advisor to Medical Assistants

Dr. Roger I. Bender of Beaver Dam has been selected medical advisor to the Dodge County Chapter of the Wisconsin State Medical Assistants Society.

Physicians Elected to ASIM

Drs. Joseph J. Skemp, La Crosse; *John E. Mielke*, Appleton; and *John G. Russo*, Kaukauna, recently were elected to membership in the American Society of Internal Medicine.

Manitowoc Physicians Guest Lecturers

Drs. John D. Best and *Joseph E. Binard* of the Manitowoc Clinic and *Dr. Michael A. Jacobi* of Holy Family Hospital, Manitowoc, recently presented papers at the annual Louvain Medical Alumni Association meeting in Milwaukee.

Drs. Weston, Puestow Retire from UW Faculty

Drs. Frank L. Weston and *Karver L. Puestow*, Madison, recently were honored at a retirement party held at the Medical Clinic of University Hospitals, Madison. Doctors Weston and Puestow were both in the Department of Internal Medicine.

Dr. Rieselbach Receives Teaching Award

Dr. Richard E. Rieselbach, assistant professor of medicine at the University of Wisconsin Medical School, Madison, recently was selected as the 1968 recipient of the Wisconsin Medical Alumni Association's award for distinguished teaching. Doctor Rieselbach graduated from Harvard Medical School in 1958.

Dr. Miller Opens Gillett Office

Dr. Donald A. Miller recently took over the practice of *Dr. F. W. Klutzow*, Gillett. He is available on a part-time basis, and by fall he plans to keep regular office hours at Suring in the former office of the late Dr. Gilbert Sandgren. Doctor Miller graduated in 1961 from the College of Medicine,

University of Illinois, Chicago. He worked part time for 2 years in cancer research in Chicago and served as a rotating intern at Cook County and Swedish Covenant hospitals, in Illinois. He served two years in the United States Air Force as a flight surgeon and previously had a medical practice in Los Angeles. Doctor Miller is a member of the staff at Community Memorial Hospital, Oconto Falls.

Dr. Quisling Featured in Paper

Dr. Abraham A. Quisling, Madison, recently was featured in "Know Your Madisonian" in a Madison newspaper. One of the founders of the Quisling Clinic, Madison, he has been a physician for over 35 years and is currently serving Madison as the president of the Chamber of Commerce. Doctor Quisling has been an active member of the county, state, and American medical societies, the state and national societies of internal medicine, Wisconsin Heart Association, the University and medical school alumni associations, and the New York Academy of Sciences. He also has served on American Medical Association committees that helped formulate the federal Medicare program.

Dr. Sivertson Accepts New Position

Dr. Sigurd E. Sivertson recently resigned his position with the Gundersen Clinic, La Crosse, to accept a post on the staff of the University of Wisconsin Medical School, Madison. He will be clinical assistant professor of medicine in the newly formed Department of Postgraduate Medical Education at the University. Doctor Sivertson has been associated with the Gundersen Clinic since 1955. He also is a new member of the State Medical Society's Commission on Scientific Medicine.

Dr. Jones Retires as Staff Chief

Dr. Merritt L. Jones, Wausau, recently retired as chief-of-staff of Wausau Memorial Hospital. Doctor Jones has been chief-of-staff since 1942 and prior to that, his father D. T. Jones was chief-of-staff starting the first day the institution admitted patients. "Dr. Merritt" is continuing as president of the board of trustees and also is continuing his practice at the Wausau Clinic. At the annual meeting of the Memorial staff, he was presented a special scroll and naming him president emeritus, a lifetime position. Doctor Jones has authored numerous medical papers including a booklet, "A Guide for Physicians Relative to Industrial Injuries," which received wide publication. He was a lecturer in industrial surgery and preceptor of the University of Wisconsin Medical School; consulting surgeon for Employers Insurance of Wausau and local surgeon for both the Milwaukee Road and North Western Railway. He was a member of the Selective Service advisory board in Wausau and worked in Civilian Defense Medical Education in World War II. For nine years he was chairman of the research bureau of the Wisconsin Conservation Department.

DR. MERRITT L. JONES, right, who retired recently as chief-of-staff of Wausau Memorial Hospital, was presented a plaque in recognition of his services by Dr. C. M. Yoran, Doctor Jones' successor, at the annual meeting of the Memorial staff. The special scroll named him president emeritus, a lifetime position. (Photo courtesy WAUSAU RECORD–HERALD)

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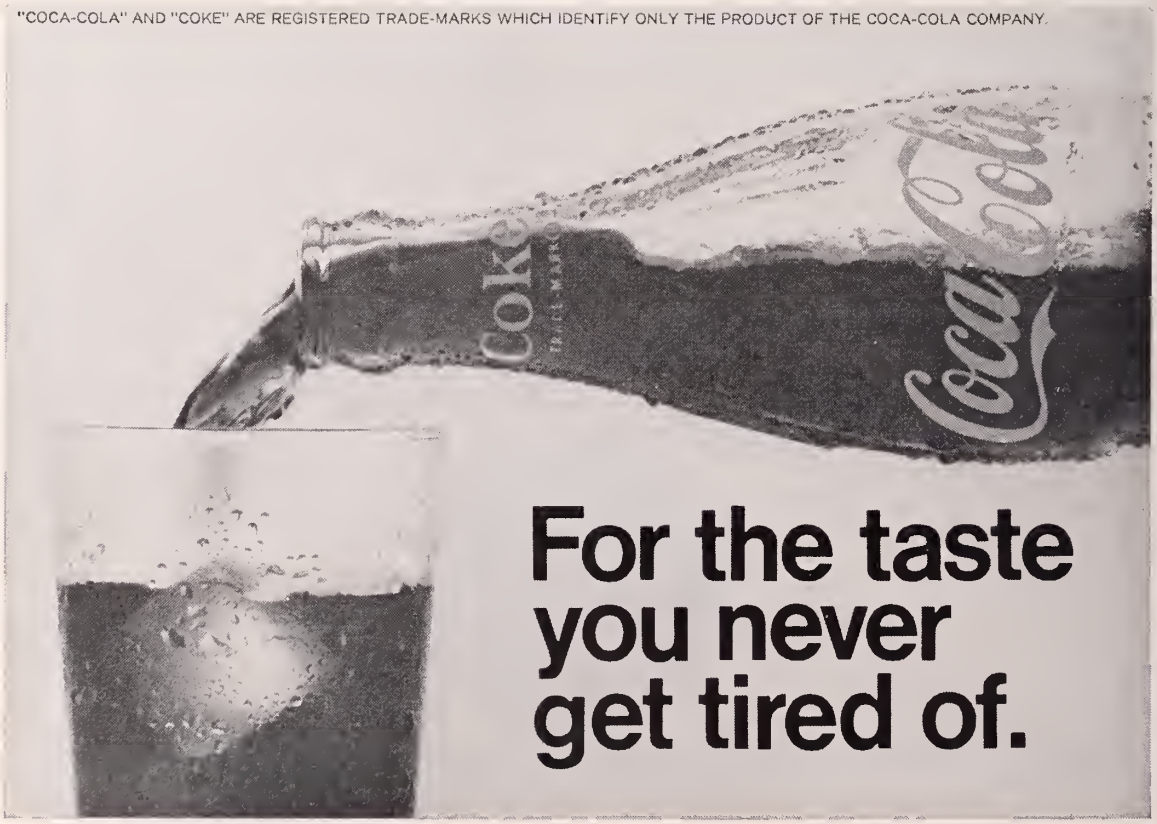

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DOUGLAS

Dr. Bittar Speaks on Coronary Artery Disease

Dr. Neville Bittar of the University of Wisconsin Cardiovascular Section spoke to members of the Douglas County Medical Society in June. His topic was "Present Concepts of Coronary Artery Disease."

DANE

Annual Golf Tournament Sept. 13

The Dane County Medical Society annual golf tourament will be held Sept. 13 at the Stoughton Country Club. Golf begins at 12:00 noon with a social hour at 6:00 followed by dinner at 7:00 o'clock. Advance reservations must be made by Sept. 11.

Dr. Vingom Honored for Service

Dr. Clair O. Vingom, a general practitioner in Madison, was honored by his colleagues June 11 for 25 years of service as medical coordinator of the Dane County Medical Society.

DR. CLAIR O. VINGOM (left) shows his plaque to Charles H. Crownhart, secretary of the State Medical Society of Wisconsin; Dr. Eugene J. Nordby, chairman of the Council; and Dr. Gordon Davenport, Jr., president of the Dane County Medical Society.

At the Society meeting he was cited for his "valuable contributions to the citizens of Dane County in programs of government medical welfare." Since 1942, Doctor Vingom occupied a key position in the city and county medical aid programs for the indigent.

Dr. Gordon Davenport, president of the Society, told the group it was Doctor Vingom's duty "to assure that patients, doctors, and welfare agencies were mutually satisfied with the medical services and allowances provided through welfare programs. Largely, as a result of his efforts, the Dane County Medical Assistance Plan became a model for the nation."

The medical coordinator position began to phase out with the start of Medicare and Medicaid in 1966. Doctor Vingom was also honored at the meeting for nearly a quarter century of service to the State Medical Society as a delegate, councilor, and former chairman of the Wisconsin Physicians Service operating committee.

Physicians whose names appear in italics are members of the State Medical Society.

WINNEBAGO

Dr. Worman Discusses Multiple Trauma

At the June meeting of the Winnebago County Medical Society *Dr. Leonard W. Worman*, associate professor of surgery at Milwaukee County Hospital, discussed "Management of the Patient with Multiple Trauma."

ASHLAND–BAYFIELD–IRON

Cancer Is Subject at June Meeting

The Ashland–Bayfield–Iron County Medical Society met June 11 to hear *Dr. Alwin E. Schultz* of the University of Wisconsin Department of Gynecology and Obstetrics talk on "Cancer of the Female Genital System and Its Treatment."

MARATHON

National Negro Leader Speaks

The president of the National Medical Association spoke to an audience of 200 June 24 at a public meeting in Wausau sponsored by the Marathon County Medical Society. Dr. Lionel F. Swan, Detroit, spoke on the causes of urban unrest and possible cures for civil disturbances.

Doctor Swan said the crisis in our cities is due to racism, poverty, and bigotry. The American Negro, he said, is still suffering from the effects of the past 400 years. Time has molded the Negro into four classes, according to Doctor Swan. The race is composed of those completely beaten down by years of oppression, groups striving to get America to keep her promises, student militants, and revolutionists.

Doctor Swan, who was introduced by *Dr. Gregory Bachhuber*, is a past president of the Detroit Medical Society and is currently on the board of directors of the National Association for the Advancement of Colored People.

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At the recent meeting of the Wisconsin Surgical Society in Milwaukee, *Dr. William D. Stovall* of Madison, president of the State Medical Society's Charitable, Educational and Scientific Foundation, presented a "Beaumont Gavel" to *Dr. John T. Mendenhall* of Madison, president of the Wisconsin Surgical Society.

"Beaumont Gavel" Presented to Wisconsin Surgical Society

Left to right:
WILLIAM D. STOVALL, M.D.
ARTHUR C. TAYLOR, M.D.
JOHN T. MENDENHALL, M.D.

The "Beaumont Gavel" was made from a piece of the original American walnut from Old Fort Crawford, Prairie du Chien. Fort Crawford was built in 1829 and is now under the title of the Museum of Medical Progress and Stovall Hall of Health, owned and operated by the State Medical Society.

It was at Fort Crawford in 1832 that Dr. William Beaumont completed his first treatise on the digestive process for which he became world renowned.

The artisan of this fine gavel is *Dr. Arthur C. Taylor* of Appleton, a member of the Wisconsin Surgical Society.

Officers of the Wisconsin Surgical Society for 1968–69 are as follows: *Dr. John T. Mendenhall*, Madison, president; *Dr. Kenneth L. Carter*, Beloit, president-elect; *Dr. Wilson Weisel*, Milwaukee, secretary-treasurer; and *Dr. Wayne J. Boulanger*, Milwaukee recorder.

Councilors are: *Drs. Thomas J. Beno*, Green Bay; *Ben R. Lawton*, Marshfield; *Edward A. Bachhuber*, Milwaukee; *Adolf L. Gundersen*, La Crosse; *B. Jack Longley*, Madison; and *Walton D. Thomas*, Milwaukee.

Officers for the State Medical Society Section on Surgery are: *Dr. John T. Mendenhall*, Madison, chairman; *Dr. Wilson Weisel*, Milwaukee, secretary; *Dr. James M. Sullivan*, Milwaukee, delegate; and *Dr. B. Jack Longley*, Madison, alternate delegate.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Samuel Asper, Jr. to Attend Internists Meeting Sept. 13–14

The Wisconsin Society of Internal Medicine and the Wisconsin members of the American College of Physicians will again join for their annual fall meeting Sept. 13–14 at the new "Pioneer" in Oshkosh. Members of both groups and their families are invited as well as all other interested physicians, and especially interns and residents.

Dr. Samuel Asper, Jr., president-elect of the American College of Physicians and associate dean for Post-doctoral Education of the Johns Hopkins University School of Medicine, will be the guest representing the college and also delivering the annual William S. Middleton lecture, honoring "The Dean," who is himself a Master and past president of the College.

Representing the American Society of Internal Medicine will be Dr. Robert V. Elliott of Denver, Colo., chairman of its committee on Family Practice, Community Health, and Health Manpower. He will participate in a panel on planning for provision of health care, as will another distinguished guest, Mr. T. A. Duckworth of Wausau, chairman of both the Wisconsin Governor's State Advisory Comprehensive Health Planning Council and the Regional Advisory Committee for the Wisconsin Regional Medical Program.

A pleasant and entertaining recreational program has been planned for the ladies. *Dr.* and Mrs. *Robert F. Madden* of Milwaukee have again organized a golf tournament, with events for members, wives, and couples.

The Friday morning, Sept. 13, welcome will be given by *Dr. J. LeRoy Sims*, Madison, ACP Governor for Wisconsin, and *Dr. Edward K. Ryder*, Madison, president of WSIM.

Dr. James W. Manier, Marshfield, WSIM president-elect, will preside at the morning program which will start at 9 o'clock with a lecture on "The Language of Immunology—An Introduction" by *Dr. Charles E. Reed*, Madison, and Fritz Bach, PhD, Madison. "Arthritis and the Immunologic Response —A Panel" will be presented by Dr. Max Montgomery of Chicago, Dr. Arthur Scherbel, Cleveland, Ohio; *Dr. Victor Bernhard*, Milwaukee; and *Dr. C. Hugh Hickey*, Milwaukee. Dr. Mark Mueller, Madison, will be moderator.

Dr. Herbert W. Pohle, Milwaukee, ACP Governor-elect for Wisconsin, will take over as presiding officer following coffee break.

Dr. Jordan Fink of Milwaukee will present the topic, "Clinical Studies in Hypersensitivity Pneumonitis," followed by Doctor Montgomery who will speak on "Reiter's Disease." "Immunosuppressive Therapy in Collagen Disease" will be given by Doctor Scherbel. *Dr. John A. Arkins* of Milwaukee will present "Some Problems in Allergic Diseases."

Doctors Arkins, Fink, Montgomery, and Scherbel will participate in a panel discussion of "Immunobiology and the Collagen Diseases" with *Dr. Charles E. Reed* as the moderator.

The Middleton Lecture will be presented following lunch. This will be followed by a panel on "Planning the Provision of Health Care" moderated by *Dr. Addis C. Costello*, Milwaukee, chairman, ASIM Committee on Office and Practice Management. The four panelists will be: Mr. T. A. Duckworth, Wausau; Dr. Robert V. Elliott, Denver; *Dr. J. D. Kabler*, Madison, assistant coordinator, Wisconsin Regional Medical Program; and *Dr. Dean Emanuel*, Marshfield.

A social hour, dinner and dancing complete the day's schedule.

Saturday morning's program starts off with a breakfast at 8:30. Doctor Asper and Doctor Elliott will give a few remarks. *Dr. James Means* of Milwaukee will preside over the morning scientific program which includes: "Immunologic Deficiency Diseases and the Development of the Immune System," by Dr. Raymond D. A. Peterson, Chicago; "Inhibition of Graft Versus Host Reaction by a Factor in the Liver," by *Dr. M. M. Bortin* of Milwaukee; "Familial Corticosterone Binding Globulin Deficiency," by *Dr. F. N. Lohrenz* of Marshfield; and "Clinical Uses of Plasma Cortisols," by *Dr. Douglas D. Klink* of Milwaukee.

Following coffee break *Dr. John M. Irvin* of Monroe will preside over a general theme of "And Some Specific Applications . . .": "Immunologic Aspects of Lymphoid Malignancies," by Dr. Raymond D. A. Peterson, Chicago; "Immunologic Approaches to the Treatment of Cancer," by *Dr. John D. Hurley*, Milwaukee; "The Thymus and Cancer," by Dr. Richard Albertini, Madison; and "Immunofluorscent Staining in Renal Diseases," by Dr. Alfred Michael, Minneapolis, Minn.; and "Tissue Compatability Matching Using Radiothymidine Tagged Blood Cells," by Fritz Bach, PhD, Madison.

The program committee consists of *Drs. James Means*, Milwaukee, chairman, *John Irvin*, Monroe, and *James Manier*, Marshfield.

Wisconsin Radiological Society

The Wisconsin Radiological Society will meet Sept. 20–22 at the Playboy Club in Lake Geneva. Dr. J. Edwin Habbe of Milwaukee will speak at the annual banquet on the subject, "Early Radiology in Wisconsin: The First Thirty Years."

Speakers and their topics for the scientific program are: Arthur R. Clemett, MD, Associate Professor of Radiology, Yale University, "Gastrointestinal Manifestations of Lymphosarcoma and Lymphoid Hyperplasia;" John B. Alberti, MD, "Pneumoencephalographic Tomography with Special Reference to the Posterior Fossa;" Timothy T. Flaherty, MD, Andrew B. Crummy, MD, Gene P. Wegner, MD, William Francyk, MD, and Florencio A. Hipona, MD, "Nonpenetrating Injuries to the Thoracic Aorta: Roentgen Considerations;"

Donald P. Babbitt, MD, "Choledochal Cysts Associated with Consistent Anomaly of the Pancreas and Common Bile Ducts;" Robert C. Feulner, MD, "Fractures of the Sacrum and Their Incidence in Fractures of the Pelvis;" and Doctor Clemett again, "Occlusion of the Portal Venous Circulation."

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SECTION OPHTHALMOLOGY

AUGUST 1968 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

CATARACT EXTRACTION THROUGH A CORNEAL INCISION

PETER A. DUEHR, M.D., Madison, Wisconsin

Frequently when glaucoma and cataract are present in the same eye, the ophthalmic surgeon must decide whether to do a cataract removal, a combined operation for both diseases, or to perform a filtering operation first, followed in a number of weeks or months by cataract extraction. Concerning the solution of this problem, one must keep in mind:

1. Some glaucoma eyes subsequent to cataract extraction heal well and the glaucoma is not too difficult to control.
2. Some of the glaucoma eyes are more difficult to control if the cataract is extracted as a primary procedure.
3. Open angle glaucoma eyes which have lost considerable field are especially in need of filtering before cataract removal; otherwise there is serious danger of losing the remaining vision because of the tendency for these eyes to have a higher intraocular pressure than they can tolerate, even though this may be 15 to 20 mm (Schiotz).
4. Large series of cases have rarely been compiled, and so we tend to be influenced considerably by our personal experience.

If now, the surgeon is faced with the problem of cataract extraction from a filtered eye, he must determine the best possible site for the incision. Many incision sites have been tried and usually the one chosen is that which the surgeon feels is the best for the case in hand and which is most likely, in his experience, to succeed. In general, we at University Hospitals favor a corneal incision about one millimeter from and parallel to the limbus around the superior half.

The preoperative preparation is not too unusual except that the vitreous in glaucomatous eyes tends to produce more than average thrust when the eye is opened, and to offset this, glycerine 1 ml/kg orally or acetazolamide (Diamox) 500 mg intravenously one hour before operation, is advised.

Retrobulbar anesthesia and digital pressure, if needed, should be employed to obtain an intraocular pressure of 6 or 7 mm of mercury (Schiotz). If the eye is too soft, the initial ab externo incision is more difficult. A scarifier knife is used to enter the anterior chamber through the cornea over the iris, usually in the 10 to 11 o'clock position. After each one third of the incision is made, 7–0 black braided silk (Ethicon 768-G) sutures are placed. A total of 9 or 10 sutures usually is needed. The iris synechiae are freed from the lens and sphincterotomies at 4:30, 6:00 and 7:30 o'clock are made if the pupil is not adequate for lens extraction and vision. Alphachymotrypsin is employed. Capsule forceps, or erisophake, or cryosurgery probe may be used. The lens may be slid or tumbled.

The postoperative patching period depends on the individual patient. Monocular cases are usually unpatched in 10 to 14 days or less. The sutures are removed in 24 to 48 days and the eyes kept patched during this time if feasible. Our results have been satisfactory using this procedure. Complications average no higher than for cataract extraction from comparable eyes through a superior limbal incision.

Summary of a presentation given at the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, Manitowoc, May 12, 1968.

Doctor Duehr is Chief of the Division of Ophthalmology, University of Wisconsin Medical Center.

DR. TAUGHER AT HALES CORNERS

Dr. Philip Taugher, who has just completed an ophthalmology residency at Marquette, has opened an office at Hales Corners.

WISCONSIN–UPPER MICHIGAN SOCIETY OF O–O

The next meeting of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology will be held Sept. 20–22 in Maxwelton Braes Resort at Bailey's Harbor. Dr. Robert Watzke of the University of Iowa will be a featured speaker for the Ophthalmology Section.

VOLUNTARY DUES ASSESSMENT

The Executive Committee reminds all Ophthalmologists that voluntary dues for the year 1968 are now being received. Voluntary contributions to the Section are used for projects specially designed to educate the public and others on medical eye care.

The regular voluntary membership contribution is $100. Educational membership contribution, for physicians who derive no part of their income from private practice, has been set at $50.

Please make your check payable to the Section on Ophthalmology and mail it to the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

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[1] Gale, E. T. and Thewlis, M. W., Geriatrics 8:80, 1953
[2] Personal Communication: R. C. Brunner, Pharmaceutical Div., Sunkist Growers

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PARAMEDICAL/ANCILLARY

Wisconsin Heart Association Names Officers

Dr. Ross Kory of Milwaukee is the new president of the Wisconsin Heart Association. He succeeds John E. Canfield of Madison. Also named president-elect at the recent 20th annual meeting of the organization in Oshkosh was *Dr. George G. Rowe* of Madison.

Doctor Kory is chief of the Cardiopulmonary Laboratory at Wood Veterans Administration Hospital in Milwaukee. He also is a professor of clinical research at Marquette School of Medicine. He has been a member of the board of directors of the WHA since 1959.

Doctor Rowe is a professor of medicine at the University of Wisconsin Medical School and is actively engaged in cardiovascular research concerning the control mechanism of the coronary artery during exercise.

Elected for membership on the board of directors for three-year terms were the following: Warren H. Dennis, PhD, Madison; *Dr. D. Joseph Freeman*, Wausau; C. Ellis Goldstein, Racine; *Dr. Joseph B. Graee*, Green Bay; Kenneth W. Haagensen, Madison; *Dr. Ramon L. Lange*, Milwaukee; *Dr. Derward Lepley, Jr.*, Milwaukee; *Dr. Hugh J. McLane*, Fond du Lac; Dr. James D. Whiffen, Madison; *Dr. John H. Wishart*, Eau Claire; and *Dr. Philip A. Zlatnik*, Two Rivers.

New Hospital Administrator, St. Francis

Sister Mary Gregory Hanson, F.S.P.A. assumed the duties of hospital administrator at St. Francis Hospital, La Crosse, July 22. She succeeds Sister M. Francita, F.S.P.A. who has been administrator since 1966. Sister is a member of the Province of Hospital Sisters, F.S.P.A. whose provincial home is in St. Paul, Minn.

Sister Mary Gregory was born in Rigby, Idaho, where she received her elementary education and graduated from Rigby High School, and entered St. Rose Convent on Aug. 27, 1949. She graduated from St. Francis Hospital School of Nursing in 1955 and from the School of Anesthesia in 1960. Sister received her B.S. Degree from Viterbo College, La Crosse, in 1958. From September 1960 until September 1966 she was the administrator of St. Joseph's Hospital, Hillsboro.

Medical School Departmental Chairmen Named

Dr. Peter L. Eichman, dean of the University of Wisconsin Medical School, Madison, has announced the following appointments of departmental chairmen for 1968–1969:

Dr. David B. Slautterback, Anatomy; *Dr. Karl L. Siebecker*, Anesthesiology; *Dr. Ben M. Peckham*, Gynecology–Obstetrics; Dr. James F. Crow, Medical Genetics; Dr. Charles V. Seastone, Medical Microbiology; Dr. Robert F. Schilling, Medicine; *Dr. Francis M. Forster*, Neurology; Dr. Harold P. Rusch, Oncology; *Dr. D. Murray Angevine*, Pathology; *Dr. Charles C. Lobeck*, Pediatrics; Dr. Lowell Hokin, Pharmacology; Dr. Philip P. Cohen, Physiological Chemistry; Dr. William B. Youmans, Physiology; Dr. Gerald W. Lawton (pro tem), Preventive Medicine; *Dr. Milton H. Miller*, Psychiatry; *Dr. John H. Juhl*, Radiology; *Dr. Arthur A. Siebens*, Rehabilitation Medicine; *Dr. Anthony R. Curreri*, Surgery; and Dr. C. N. Woolsey, Laboratory of Neurophysiology.

Physicians whose names appear in italics are members of the State Medical Society.

Refresher Courses for Inactive Nurses

The Department of Nursing, University of Wisconsin is tentatively planning to offer a non-credit course for nurses who are planning to return to active practice and are interested in a refresher course. There will be no fee as the course is being funded under the Manpower Development Training Act.

Tentative dates and locations: KENOSHA, Sept. 9–Oct. 3; WAUKESHA, Oct. 8–Nov. 2; FOND DU LAC, Sept. 10–Oct. 4; SHEBOYGAN, Sept. 16–Oct. 10; RACINE, Oct. 7–Nov. 1; OSHKOSH, Oct. 8–Nov. 2.

For further information, call or write Miss Elizabeth A. Swenehart, State Coordinator, Inactive Health Personnel Project, Room 1005—West Towers, 606 State St., Madison, Wis. 53706; tel. (608) 262–0566, or (608) 233–2581, or the Nursing Office of your local hospital.

Wisconsin Nurses Association to Meet

Jessie M. Scott, RN, newly elected second vice-president of the American Nurses Association, will be a featured speaker at the annual convention of the Wisconsin Nurses Association, Oct. 9–11 at the Sheraton–Schroeder Hotel in Milwaukee. The convention theme is "Sharing the Caring."

Several nationally prominent persons will head the program, including James De Marco, RN, director of nursing, Children's Hospital of Akron, Ohio; Frank E. X. Dance, PhD, director of the speech communication center, University of Wisconsin–Milwaukee; Eleanor C. Lambertsen, RN, director of Division of Nursing Education, Teachers College, Columbia University, N.Y.; and Inez Hinsvark, RN, dean of the School of Nursing, University of Wisconsin–Milwaukee.

Other activities are being planned and there will be meetings of special committee groups. All Wisconsin nurses, regardless of membership in the WNA, are welcome to all convention programs. For details, contact Mrs. Alice A. Weldy, RN, Executive Secretary, WNA, 161 West Wisconsin Ave., Room 6012, Milwaukee, Wis. 53203.

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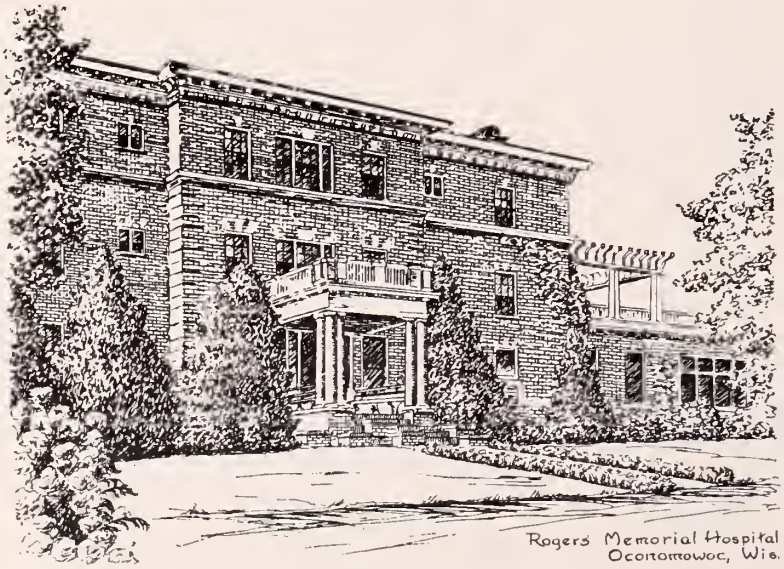

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OBITUARIES

Dr. John J. Wilkinson, 74, Milwaukee, died May 28, 1968, in Milwaukee.

Doctor Wilkinson graduated from Loyola University School of Medicine in 1916 and interned at St. John's Hospital, Springfield, Ill. He served in the United States Army Medical Corps in World War I.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Sally, and a brother, Dr. Edward Wilkinson, West Allis.

Dr. F. Gregory Connell, 93, Oshkosh, died May 29, 1968, in Oshkosh.

Doctor Connell graduated from Rush Medical College in 1896 and spent his internship at Alexian Brothers Hospital, Chicago. He was an associate professor of surgery at the University of Illinois from 1898 to 1901. Doctor Connell, a past president of the State Medical Society of Wisconsin, was one of the founders of the American Board of Surgery and the American College of Surgeons and also was the first president of the Wisconsin Surgical Society. He served as attending surgeon at St. Mary's and Mercy Hospitals and was a consulting surgeon for a number of years at Winnebago State Hospital.

In 1948, he was honored as a 50-year club member of the State Medical Society of Wisconsin and in the same year he was honored by Theda Clark Hospital where he had served as consulting surgeon since its inception. He also was a member of the Gastroenterology Society, International College of Surgeons, and the Western Surgical Society.

Doctor Connell also was a past president of the Winnebago County Medical Society and a member of the American Medical Association.

Surviving are a son, Charles, Chicago; and a daughter, Dr. Jane Card, San Francisco.

Dr. George G. Stebbins, 64, prominent Madison physician, died June 2, 1968, in Madison.

Doctor Stebbins graduated from Harvard School of Medicine in 1928 and interned in New York City. He taught six years at the University of Wisconsin Medical School and joined his father in 1936 in the practice of medicine. His father, Dr. Walter W. Stebbins, preceded him in death on March 12, 1968.

Doctor Stebbins, active in community affairs, served as two-term director of the Madison Community Chest, was a member of the original committee which worked to establish a blood bank in Dane County, was on the Wisconsin Board of Health as an advisor to nursing homes, and was chairman of the Division of Aging of the Commission on State Departments of the State Medical Society.

He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are three sons: Dr. George G., Jr., and Walter W., Madison, and Major Ronald S., Ft. Rucker, Ala., and a daughter, Mrs. Victoria Lee Thomas, Mazomanie.

Dr. Saul E. Biller, 67, Milwaukee, died June 8, 1968, in Milwaukee.

Doctor Biller graduated from the Marquette University School of Medicine in 1925 and interned at

Reprinted with permission from
WISCONSIN STATE JOURNAL, June 4, 1968

HE SERVED YOUNG AND OLD

Dr. George G. Stebbins

Nothing is more estimable than a physician who, having studied nature from his youth, knows the properties of the human body, the diseases which assail it, the remedies which will benefit it, exercises his art with caution, and pays equal attention to rich and the poor.
—**Voltaire.**

Madison is a better place to live for both young and old because Dr. George G. Stebbins spent his dedicated life in this capital city.

Dr. Stebbins, who died Sunday, not only practiced medicine among us, but practiced the noble virtues of a good citizen who was concerned for his community and its people.

A member of the Madison medical community since 1931, Dr. Stebbins gave of his precious time and many talents for the good of his fellow man, teen-agers and senior citizens alike.

The doctor was a member of the original committee which worked to establish a blood bank in Dane County. His 30-year membership and leadership in Madison's YMCA was most beneficial to the younger people of Madison. He served on the committee that established the YMCA's first teen-age center.

While serving the cause of youth, Dr. Stebbins also showed deep concern for the elderly and was envolved in geriatric work ever since the committee on aging was formed more than 17 years ago. He also served his state as an adviser to nursing homes.

While Dr. Stebbins earned an impressive list of civic credits in his active lifetime, he always remained the dedicated physician with a deep, personal concern for the ills and problems of his fellow man.

His was a life worth living and the many whose lives he touched will long remember him.

OBITUARIES *continued*

St. Joseph's Hospital, Ashland. In 1953 he received a fellowship in Surgery from the International College of Surgeons and in 1954 was president of the Milwaukee chapter of the American Academy of General Practice.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Mildred; and two sons, Joel W., Quito, Ecuador, and Dr. Hugh F., St. Louis, Mo.

BOOKLET: WISCONSIN NURSING PIONEERS

The contributions of the early nursing leaders in Wisconsin are documented in a recently published book entitled "Wisconsin Nursing Pioneers." The 40-page book was written by Signe S. Cooper, R.N., professor of nursing, University Extension, University of Wisconsin, which is the publisher.

Among the well known names in the book are Cordelia Harvey, Helen Kelly, Elizabeth Leenhouts, and Edith Partridge.

The book may be purchased for $1.00 from: Bookstore, University Extension, The University of Wisconsin, 432 North Lake Street, Madison, Wis. 53706.

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BOOKSHELF

BOOKS RECEIVED

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

DECISION MAKING IN NATIONAL SCIENCE POLICY

Ciba Foundation Symposium, edited by Anthony De Reuck, Maurice Goldsmith and Julie Knight. Little, Brown & Co., Boston, 1968. 324 pages. Price: $12.00.

INTERFERON

Ciba Foundation Symposium, edited by G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown & Co., Boston, 1968. 284 pages. Price: $12.00.

NUTRITION AND INFECTION

Ciba Foundation Group #31. Little, Brown & Co., Boston, 1968. 151 pages. Price: $3.50.

PEDIATRIC THERAPY: 1968–1969 (3rd Edition)

Edited by Harry C. Shirkey, M.D., Published by C. V. Mosby Co., St. Louis, Mo., 1968. 1294 pages. Price: $25.00.

THE CARE OF THE GERIATRIC PATIENT (3rd Edition)

Edited by E. V. Cowdry, Ph.D., Consultant to the Jewish Hospital of Saint Louis. Published by C. V. Mosby Company, 1968. 430 pages. Price: $15.75.

THE COUNTRY DOCTOR AND THE SPECIALIST

By Fred Lyman Adair, M.D., Adair Award Fund, Box 65, Maitland, Florida 32751. 215 pages.

MODERN TREATMENT

Vol. 5, No. 1. Treatment of Hemorrhagic Disorders, guest editor, Oscar D. Ratnoff, M.D.; and Treatment of Disorders of Growth and Development, guest editor, Roberto F. Escamilla, M.D. Hoeber Medical Division, Harper & Row, Publishers, 49 East 33 St., New York, N. Y. 10016. Published bimonthly. 1,500 pages annually. Subscription: $16 per year.

INTERNAL MEDICINE—Based on mechanisms of disease

Edited by Peter J. Talso, A.B., M.D., F.A.C.P., F.A.C.C., professor and chairman, Dept. of Medicine, Loyola University Stritch School of Medicine, Hines, Ill.; and Alexander P. Remenchik, B.S., M.D., F.A.C.P.,

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

July 1, 1968–December 31, 1968

STATE DEPARTMENT OF PUBLIC INSTRUCTION

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MADISON, WISCONSIN 53702

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Ashland	August 15 and 16	Kenosha	October 9 and 10
Stevens Point	August 21	La Crosse	October 16 and 17
Manitowoc	August 28 and 29	Chippewa Falls	October 23 and 24
Superior	September 11	Rhinelander	November 6 and 7
Racine	September 18 and 19	Sheboygan	November 13 and 14
Eau Claire	October 2 and 3		

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REFERRAL FORMS: Referral forms may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for each clinic so when requesting same be sure to state how many forms are needed and for which clinic. It is important that we know well in advance the number desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

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BRAND THIPHENAMIL HCl.

BOOKSHELF *continued*

professor and asst. chairman, Dept. of Medicine, Loyola University Stritch School of Medicine, Hines, Ill. Published by C. V. Mosby Co., 1968. 797 pages. $17.50.

STATE LICENSING OF HEALTH OCCUPATIONS

U. S. Dept. of Health, Education, & Welfare, Public Health Service, National Center for Health Statistics, Washington. D.C. PHS publication no. 1758. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 171 pages. Price: $1.25.

BOOK REVIEWS

SYMPOSIUM ON SURGERY OF THE OCULAR ADNEXA

Transactions of the New Orleans Academy of Ophthalmology. Seven contributors. C. V. Mosby Co., St. Louis, April 1966. 245 pages. Price: $16.

This manual is one of the latest in the series of excellent publications derived from the annual meetings of the New Orleans' Academy of Ophthalmology. The seven contributors are experts in adnexal and lacrimal surgery and they give thorough and practical discussions of the diagnosis and surgical management of lid, lacrimal and orbital problems with emphasis on the technics that they personally have found most satisfactory.

The final 40 pages are devoted to an excellent round table discussion in which differences of opinion among the individual authors are brought out and discussed. The chapter on ptosis is somewhat brief and poorly illustrated and would not serve as an adequate guide to the inexperienced lid surgeon. The chapter on dacryocystography is possibly somewhat redundant.

Since this is a symposium and does not pretend to be a textbook of ophthalmic plastic surgery, adequate illustrations and discussions of alternative methods of surgery are, in many cases, lacking.

This volume is highly recommended as an adjunct to the standard textbooks of ophthalmic plastic surgery to any ophthalmologist interested in this field.—FREDERICK J. DAVIS, M.D.

HERITABLE DISORDERS OF CONNECTIVE TISSUE

By Victor A. McKusick, M.D., professor of medicine, Johns Hopkins University School of Medicine, and physician at Johns Hopkins Hospital, Baltimore. Third edition. C. V. Mosby Co., St. Louis. 1966. 499 pages. Price: $18.50.

Now that the genetic backgrounds of a wide variety of diseases are being clarified, it is possible to take an entirely different overview of a large number of poorly understood and relatively rare disease entities. Dr. McKusick has again updated his classic book on heritable disorders of connective tissues so that many disorders are more clearly understood and an increasing number of interrelationships are now evident. This book is a veritable gold mine of information that is lucidly presented and well documented with references.

It is a must for the library of pediatricians, internists, and others concerned with lesions that are inherited.

SURGERY OF THE BREAST

By Louis H. Jorstad, M.D., F.A.C.S., F.I.C.S., Consulting Surgeon, St. Luke's Hospital, Missouri Baptist Hospital and Frisco Employees' Hospital Association, St. Louis, Mo. C. V. Mosby Co., St. Louis, Mo. 1964. 220 pages. Price: $15.00.

This book covers many aspects of the physiology, pathology, and management of many breast disorders, both benign and malignant. The strongest chapters are on the physiologic changes in the breast and hypertrophies of the breast which generally are not covered well in other texts on the subject. Most of the other chapters cover the more routine discussions as to the management of breast disorders. None of the chapters could be considered a treatise on the management of a specific problem. The major weakness lies in the bibliography which is primarily at the end of the book rather than at the end of the chapters and is not numbered according to reference. In other areas, however, the bibliography is identified and listed at the bottom of the page in the text. This makes for some confusion when the chapters are initially read because the differences are not identified. The index, on the other hand, is very complete and usable.

In general, one could consider *Surgery of the Breast* a good book; but, its main value would be for the medical student and the surgeon initially in his training. Certainly it could not be considered a must in every surgeon's library.—SANFORD MACKMAN, M.D.

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CONTENTS

Vol. 67, No. 9 SEPTEMBER 1968

SCIENTIFIC ARTICLES

Superior Mesenteric Arterial Embolectomy; report of a case with survival, by William M. Stoll, M.D., Green Bay ---------- 403

Granular Cell Myoblastoma; report of three cases in the chest wall and review of the literature, by David B. Apfelberg, M.D. and Jack L. Teasley, M.D., Milwaukee -- 405

Removal of a Giant Hairy Nevus and Coverage of the Resultant Defect with a Mesh-graft; case report, by Edmund B. Jacobs, M.D., Madison ---------- 409

Cycle Injuries; a comparative study, by Ernest A. Pellegrino, Jr., M.D., Madison ------ 413

Therapeutic Dilemmas: Chronic Obstructive Lung Disease and Cor Pulmonale (No. 11 of a Series), by Harry Beckman, M.D., Milwaukee ---------- 418

Comments on Treatment: Rh Immunoglobulin and Its Use in Preventing Erythroblastosis, by Daniel F. Johnson, M.D. and Alfred L. Kennan, M.D., Madison ---------- 424

SPECIAL FEATURES

Familial Polyposis of Colon (abstract) ---- 404

Wisconsin's Health: Alcohol Involved in Most Driver Deaths, by E. H. Jorris, M.D., Madison ---------- 417

Pigeon Breeders' Disease: A Clinical Study of a Hypersensitivity Pneumonitis (abstract) - 423

A Statement of the Current Status of Normal (Whole, Pooled) Human Plasma ------- 427

Medical-School Dean Checks Up on Country Doctors ---------- 428

Medical Library Services in Wisconsin, by Virginia Holtz, B.S. and Helen Crawford, Ph.D., Madison ---------- 439

Medicare Report No. 5: When Care Furnished to ECF Patients Can Be Covered by Medicare ---------- 429

House of Delegates Reports and Proceedings of May 1968 Session (supplement) ----- 445

List of State and County Medical Society Officers ---------- 503

List of Officers and Board of Trustees of the Charitable, Educational and Scientific Foundation ---------- 506

Medical Memo: Museum of Medical Progress and Stovall Hall of Health ---------- 507

EDITORIALS

President's Page: Education Is Key to Health Quackery Menace, by W. D. James, M.D., Oconomowoc ---------- 425

The Case for PACE ---------- 426

REGULAR FEATURES

Publication Information ---------- 6

Medical Meetings ---------- 7

Medical Green Sheet ---------- 431

State Medical Society ---------- 39

County Societies ---------- 43

Specialty Societies ---------- 45

Section on Ophthalmology ---------- 47

Physician News ---------- 49

Paramedical/Ancillary ---------- 53

Obituaries ---------- 57

Society Records ---------- 58

Physicians Exchange ---------- 60

Index to Advertisers ---------- 62

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Journal
Established 1903

Annual Subscription -----$10.00
Single Copy ---------- 1.50
Previous Years' -------- 3.00
January Blue Book ------ 5.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago, Illinois 60610; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin 54481.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 WISCONSIN

Oct. 1–4: Sixth annual Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Oct. 2: Pulmonary Thromboembolism Conference, sponsored by The Wisconsin Regional Medical Program, Coffey Auditorium, Milwaukee County Hospital, Milwaukee.

Oct. 3: Pulmonary Thromboembolism Conference, sponsored by The Wisconsin Regional Medical Program, Employers Insurance Company of Wausau, Wausau.

Oct. 5: 14th Annual Fall Cancer Conference (The Cancer Scrimmage), University of Wisconsin Medical Center, Madison.

Oct. 7–11: Postgraduate course on "Computers in Medicine," American College of Physicians, at University of Wisconsin Medical School, Madison.

Oct. 8–11: Meeting of the Wisconsin Nurses Association, Sheraton-Schroeder Hotel, Milwaukee.

Oct. 9–10: Meeting of Wisconsin Division, American Cancer Society, Oshkosh.

Oct. 16: First Octoberfest Clinic Day, West Allis Memorial Hospital, West Allis.

Nov. 16: Fall annual meeting of Wisconsin Society of Pathologists, Marquette School of Medicine, Milwaukee.

1968 NEIGHBORING STATES

Oct. 12–18: Annual Otolaryngologic Assembly of 1968, Illinois Eye and Ear Infirmary at the Medical Center, Chicago, Ill.

Oct. 18: Seminar on "Surgical Management of Chronic Arthritis," Illinois Chapter of The Arthritis Foundation, Sherman House Hotel, Chicago.

Oct. 19–24: Annual meeting, American Academy of Pediatrics, Palmer House Hotel, Chicago, Ill.

Oct. 28–30: Clinical Reviews, Mayo Clinic and Mayo Foundation, Rochester, Minn.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

Nov. 11–13: Clinical Reviews, Mayo Clinic and Mayo Foundation, Rochester, Minn.

1968 OTHERS

Oct. 4–8: Tenth International Congress on Diseases of the Chest, American College of Chest Physicians, Washington Hilton Hotel, Washington, D.C.

Oct. 6–11: XVI Biennial International Congress, International College of Surgeons, Tokyo, Japan.

Oct. 7–12: "Stress and Disease—The Relationship of Psychologic and Social Forces in Pathogenic Mechanisms, American College of Physicians, University of Oklahoma Medical Center, Oklahoma City, Okla.

Oct. 9–11: 15th Western Cardiac Conference, University of Colorado Medical Center, Denver, and Colorado Heart Association.

Oct. 15–18: 51st Annual Meeting, American Dietetic Association, San Francisco, Calif.

Oct. 16–26: Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, International College of Surgeons.

Oct. 21–25: "Current Concepts of Neurology—Diagnosis and Treatment," American College of Physicians, University of Maryland School of Medicine, Baltimore, Md

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

Oct. 27–29: Scientific session on "Electrolyte Metabolism and Renal Diseases," Pennsylvania Medical Society, Chatham Center, Pittsburgh.

Oct. 27–28: Annual Leadership Conference, American Social Health Association, Hotel Biltmore, New York, N.Y.

Oct. 28–Nov. 1: "Rheumatic Diseases—Pathology Diagnosis and Treatment, American College of Physicians, Harvard Medical School (Robert B. Brigham Hospital), Boston, Mass.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

Oct. 31–Nov. 1–2: Annual course in Postgraduate Gastroenterology, American College of Gastroenterology, Statler Hilton, Boston, Mass.

Nov. 7–9: Second Annual Postgraduate Conference on "Today's Hospital Problems: An Interdisciplinary Approach," Mound Park Hospital Foundation with joint sponsorship of the University of Florida's J. Hillis Miller Health Center, The Tides Hotel and Bath Club, Redington Beach, Fla.

Nov. 11–14: Interstate Postgraduate Medical Association Assembly, Pittsburgh, Pa.

Nov. 11–15: "Cancer and Internal Medicine," American College of Physicians, Memorial Hospital for Cancer and Allied Diseases, New York, N.Y.

Nov. 13–16: Forty-seventh annual convention, National Easter Seal Society for Crippled Children and Adults, Sheraton-Boston Hotel, Boston, Mass.

Nov. 19–20: 22nd Annual Meeting, American Heart Association Council on Arteriosclerosis, Bal Harbour, Fla.

Nov. 20–22: Sixtieth annual conference, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Nov. 21–24: 41st Scientific Sessions, American Heart Association, Bal Harbour, Fla.

Nov. 22–23: Psychedelic Drugs meeting, The Hahnemann Medical College and Hospital of Philadelphia, Pa.

Nov. 25–26: Annual Assembly Meeting, American Heart Association, Bal Harbour, Fla.

Nov. 25–26: Meeting, American Society of Nephrology, Shoreham Hotel, Washington, D.C.

Dec. 2–6: "Physical Methodology in Medical Research," American College of Physicians, Massachusetts Institute of Technology, Cambridge, Mass.

Dec. 10–13: "Cardiology—1968," Institute for Cardiopulmonary Diseases of Scripps Clinic and Research Foundation, American College of Cardiology, La Jolla, Calif.

Dec. 13–15: "Advances in Coronary Artery Disease," American College of Cardiology, Waldorf-Astoria Hotel, New York, N.Y.

1968 AMA

Oct. 5–6: Second National Congress on Medical Ethics, Judicial Council of the AMA, Drake Hotel, Chicago, Ill.

Dec. 1: Tenth National Conference on the Medical Aspects of Sports, AMA, Hotel Deauville, Miami Beach, Fla.

Dec. 1–4: Clinical Convention, AMA, Miami Beach, Fla.

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April 14–18, 1969

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October 28–30, 1968 (Limited)

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November 13, 1968

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November 14–16, 1968

CRISIS RECOGNITION AND TREATMENT
January 12, 1969

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January 13–18, 1969

DIAGNOSTIC ULTRASOUND
March 10–12, 1969

OBSTETRICS AND GYNECOLOGY
April 14–17, 1969 (Colo. Springs, Colo.)

MANAGEMENT AND CARE OF RESPIRATORY INSUFFICIENCY
April 7–9, 1969

CLINICAL DERMATOLOGY
April 24–26, 1969 (Limited)

MEDICAL TECHNOLOGY
May 5–9, 1969 (Estes Park, Colo.)

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MEDICAL MEETINGS *continued*

1969 NEIGHBORING STATES

April 20–25: 50th Annual Session, American College of Physicians, Conrad Hilton Hotel, Chicago, Ill.

Apr. 30–May 4: M.A.C. VI-Midwest Anesthesiology Conference, Illinois Society of Anesthesiologists, Palmer House, Chicago.

1969 OTHERS

Jan.: AHA Council on Clinical Cardiology—"Cardiopulmonary Physiology," San Francisco, Calif.

Jan. 12–17: Annual meeting, Society for Cryosurgery, Hilton Piaza, Miami Beach, Fla.

Feb. 3–5: Sectional meeting, American College of Surgeons, featuring general surgery, urology, orthopedics, Fontanelle Hotel, Omaha, Neb.

Feb. 8–13: Annual Congress and Teaching Seminar, International Academy of Proctology, Hollywood Beach Hotel and Country Club, Hollywood, Fla.

Feb. 24–26: Sectional meeting, American College of Surgeons, featuring gynecology-obstetrics, neurosurgery, general surgery, and symposium on trauma, Brown Hotel, Louisville, Ky.

Mar. 10–12: Joint meeting for doctors and nurses, American College of Surgeons, featuring general surgery and eight surgical specialties, Sheraton–Boston Hotel, Boston, Mass.

Mar. 28–30: International Congress (Giornate Mediche Internazionali) featuring molecular pathology, endoscopy, blood circulation and respiratory apparatus, and psycho-pharmaceutics, Istituti Ospitalieri of Verona (Italy).

Apr.: AHA Council on Clinical Cardiology—"Clinical Electrocardiography and Vectorcardiography," Augusta Ga.

Apr. 18: Annual symposium on Infectious Diseases, American Academy of General Practice, Battenfield Auditorium, Kansas City, Kan.

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

June: AHA Council on Clinical Cardiology, title and location to be announced.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Winter: AHA Council on Clinical Cardiology—"Clinical Use of Cardiovascular Drugs," La Jolla, Calif.

1969 AMA

July 13–18: Annual meeting, American Medical Association, New York City.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

1970 OTHERS

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Clinic Day, West Allis Hospital

Various aspects of immunology will be discussed at the first Octoberfest Clinic Day to be held at West Allis Memorial Hospital Wednesday, Oct. 16. The program will begin at 10:30 in the morning and conclude in the evening with a dinner.

Outstanding guest faculty: Eugene McKelvey, MD, Northwestern U, *Alterations in Serum Immunoglobulins;* Jan Karl-Erik Hirschfeld, MD, PhD, U of Wisconsin, *Introduction to Human Immunogenetic Systems;* Charles B. Carpenter, MD, Harvard, *Immunology in Organ Transplantation;* and Charles F. McKhann, MD, U of Minnesota, *Immunology in Malignancy.*

Registration fee: $10 (register before Oct. 11). Further information: Daniel P. Collins, MD, program chairman, West Allis Memorial Hospital, 8901 W. Lincoln Ave., West Allis, Wis. 53227.

Course on Use of Computers

The American College of Physicians (ACP) will sponsor a five-day postgraduate course on "Computers in Medicine," Oct. 7–11, at the University of Wisconsin Medical School, Madison.

The session is one of 24 postgraduate courses being held throughout the United States by the ACP during the current academic year to help specialists in internal medicine keep abreast of new knowledge affecting the diagnosis and treatment of diseases.

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The course is under the direction of J. LeRoy Sims, MD, Madison, ACP Governor for Wisconsin and Professor of Medicine, University of Wisconsin Medical School. He will be aided by Warner Slack, MD, Madison, Assistant Professor of Medicine, and Karver Puestow, MD, Madison, Professor of Medicine, both with the University medical school.

For registration and applications: Edward C. Rosenow, Jr., MD, Executive Director, The American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Interstate Scientific Assembly

The 53rd annual scientific assembly of the Interstate Postgraduate Medical Association will be held Nov. 11–14 at the Pittsburgh Hilton Hotel, Pittsburgh, Pa.

Contact: IPMA, 333 North Randall Ave., Madison, Wis. 53706.

American Social Health Association Conference

Venereal disease, infecting Americans at an unprecedented rate, will be topic *A* at the annual leadership conference of the American Social Health Association in New York City Oct. 27–28.

An address on "More Promiscuity or More Talk with More Freedom from Pregnancy" will be presented on Oct. 28 by John H. Gagnon, PhD, senior research sociologist, Institute for Sex Research, University of Indiana.

Conference attendees can register early by forwarding a check or money order for $35, which covers the essential dinner and luncheon sessions, to the American Social Health Association, 1740 Broadway, New York, New York 10019.

Pennsylvania Seminar

The 1968 scientific session of the Pennsylvania Medical Society will be held Oct. 27–30 at the Chatham Center, Pittsburgh, Pa. Oct. 27 will be

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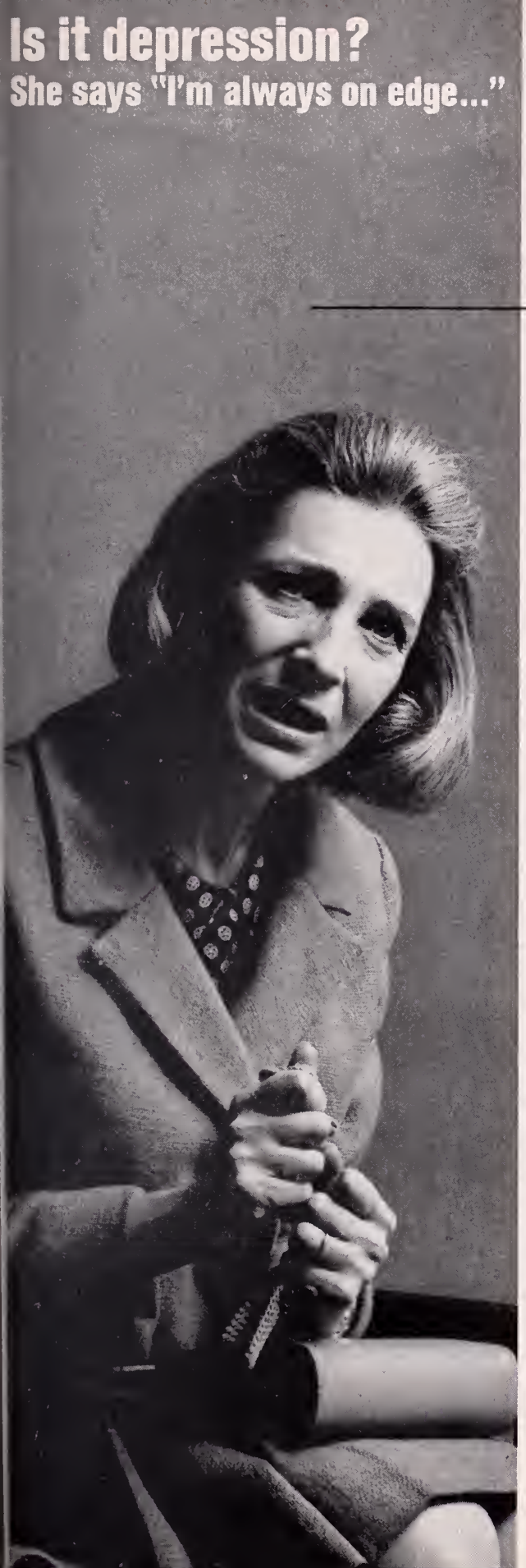

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Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

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devoted to a seminar for physicians on "Electrolyte Metabolism and Renal Diseases." A seminar on "Renal Diseases for Allied Professions" will be held Oct. 28, and on Oct. 30 a number of specialty societies will conduct separate meetings.

An evening program on Oct. 28 will feature the subject "The Status of Organ Transplantation."

Contact: Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pa. 17043.

Seminar on Chronic Arthritis, Chicago

The medical and scientific committee of the Illinois Chapter of The Arthritis Foundation will present a one-day professional seminar on "Surgical Management of Chronic Arthritis" (Rheumatoid Arthritis, Osteoarthritis, Gout, Pre- and Postoperative Treatment), Friday, Oct. 18 from 9 a.m. to 5 p.m. at the Sherman House Hotel, Chicago, Ill.

Contact: Illinois Chapter, The Arthritis Foundation, 159 North Dearborn, Chicago, Ill. 60601; tel. 782-1367.

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Walter Blount, M.D., Milwaukee

255. TREATMENT OF ACUTE ALCOHOL WITHDRAWAL
Samuel C. Kaim, M.D., Washington

256. TREATMENT OF TOXEMIA AND ECLAMPSIA, Part I—Control of Convulsions and Blood Pressure
Everett L. Roley, M.D., Madison

257. TREATMENT OF TOXEMIA AND ECLAMPSIA, Part II—Delivery of Patient and Prognostic Signs
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A new brochure, listing all tapes through 257, with Emergency Listing and Index was distributed through hospitals in early September. Be sure you get a copy!

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Moderator for both programs: Richard Sautter, MD, Marshfield

(Details of program mailed to all physicians the latter part of August)

GUEST SPEAKERS

Arthur A. Sasahara, MD, Boston, Assistant Chief of Medical Service at Veterans Administration Hospital, West Roxbury, Mass.; Assistant Pediatric Cardiologist at Children's Medical Center, Boston, and on the staff of the Department of Medicine at Harvard University Medical School.

M. S. DeWeese, MD, Columbia, Mo.; Professor and Chairman of the Department of Medicine at the University of Missouri School of Medicine.

William S. Middleton, MD, Madison, former Dean at the University of Wisconsin Medical School, and former Administrator of the Veterans Administration in Washington, D.C., and currently consultant and teacher at the VA Hospital in Madison.

AAGP Educational Credit Allowed

Reservations to: Roy T. Ragatz, Wis. Regional Medical Program, 333 N. Randall Ave., Madison, Wis. 53706.

Museum Open House Draws 500

Sipping cider was the order of the day at Prairie du Chien July 26 when over 500 persons visited the Museum of Medical Progress and Stovall Hall of Health at an Open House event. World famous Kickapoo Valley apple cider was served from 5:00 to 9:00 p.m. to all visitors who thoroughly enjoyed the Southwestern Wisconsin hospitality.

Many communities in Wisconsin were represented at the Open House as well as Iowa, Illinois, Indiana, North Dakota, California, Michigan, Minnesota, West Virginia, and as far away as Germany.

The Museum is open regularly, seven days a week, from April 15 through November 1. The State Medical Society's CES Foundation owns and operates the historic site. At the end of July there had been 12,512 visitors for this season.

Wisconsin Work Week of Health

The State Medical Society headquarters in Madison will be swarming with people Oct. 1–4 when nationally prominent persons will speak to the invited public on subjects related to the youth of America during the sixth annual Wisconsin Work Week of Health. Program details appear in the GREEN SHEET section of this issue.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF AUGUST 1968

5 Joint Committee on Certification of Health Teachers
6 Board of Directors, Woman's Aux. to SMS
6 Board of Trustees, Dane Co. Med. Soc.
7 Board of Trustees, SMS Realty Corp.
12 Advisory Committee on Extended Care Facilities, Dane County Medical Society
16 SMS Commission on Scientific Medicine
17 Executive Committee of SMS Council with Representatives of Wisconsin Regional Medical Program and Comprehensive Health Planning
18 Subcommittee, SMS Division on Maternal and Child Welfare of the Commission on State Departments
22 Executive Committee, SMS Commission on Medical Care Plans
28 Advisory Committee on Health Careers and Board of Directors of Wisconsin Health Council
28 Cardiology Study Committee, Wis. Reg. Med. Program

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics, with the location in parentheses.

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MONROE

County Eye-Care Program Launched

A Monroe County eye care program was launched at a meeting of the Monroe County Medical Society, July 29. Emphasis will be on the importance of early visual screening for three, four, and five-year-old children. *Dr. E. O. Lukasek*, secretary of the Society, was instrumental in developing the program with other health groups and interested volunteers.

RACINE

Society Urges County Health Dept.

At a public hearing July 24, *Dr. Arthur J. Jacobsen*, president of the Racine County Medical Society, urged passage of a proposal now under consideration by the Racine County Board's Health and Hospital Committee for a countywide health department. Doctor Jacobsen pointed out that a countywide department could standardize sanitation control, inspection of eating places, grocery stores, and public meeting places, and health services for children in schools.

ROCK

Guidance Clinic Services Studied

At a recent meeting of the Rock County Medical Society, members discussed a countywide survey on the need for expanded Guidance Clinic services in Rock County. Speakers were Joseph Schiro, administrator and chief social worker of the Guidance Clinic, and Dr. Harold Borenz, psychiatrist–director of the Clinic. The subject of starting preventive services for mothers of new babies was brought up. It was noted that part of this service would involve checking reactions of children at various stages of development.

WAUKESHA

Awards Two Scholarships

Two Waukesha County residents recently received "SOS" scholarships from the Waukesha County Medical Society. They are: David C. Brown of Mukwonago and Miss Leslie Leppla of New Berlin. Mr. Brown has completed two years at the University of Wisconsin—Waukesha and will be entering his third year studies in pharmacy at the University of Wisconsin—Madison. Miss Leppla will be starting her third year of medical studies at the University of Wisconsin Medical School.

Drs. Henry H. Gale and *Paul F. Hausmann* of Milwaukee were recent speakers at the monthly meeting of the Waukesha County Medical Society; their subject: Procedures in Vascular Surgery and Prognostics. Fifty-five members were present.

Business matters discussed involved, press coverage of attempted suicides, whether such coverage violates the key "doctor–patient" relationship in addition to being detrimental to the patient's eventual recovery; and unfavorable publicity accorded physicians in Waukesha County by an article published in the WAUKESHA FREEMAN relating to a Medicare billing.

RICHLAND

Dr. Fred Ansfield of the University of Wisconsin Department of Oncology, Madison, talked on "Cancer Chemotherapy in Community Hospitals" at the July 11 meeting of the Richland County Medical Society.

WINNEBAGO

Back Implied Consent Proposal

At its June 6 meeting the Winnebago County Medical Society adopted a resolution in favor of the implied consent suggested law "in an effort to control the slaughter on the highways by those individuals who tend to indulge in alcohol while driving."

OUTAGAMIE

Arthritis Sufferers To Have Program

The Outagamie County Medical Society is cooperating with the Wisconsin Arthritis Foundation and St. Elizabeth Hospital, Appleton, in an action program for arthritis sufferers.

The Arthritis Foundation is establishing an information and referral service through which arthritis sufferers may obtain information on the latest treatment procedures and management techniques available. At the same time, St. Elizabeth Hospital is establishing an arthritis treatment service to which physicians may refer arthritis patients for treatment in the physical and occupational therapy departments.

The program will operate under the medical supervision of an arthritis committee of the Outagamie County Medical Society.

DANE

Supports Foreign Student Program

The Dane County Medical Society this summer helped support a pilot project in which six foreign medical students from France, Scotland, Spain, and Switzerland learned about medical practice in Madison hospitals.

The program, International Medical Student Fellowships of University of Wisconsin Affiliated Hos-

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COUNTY SOCIETIES *continued*

pitals, included five-week educational assignments in medicine, surgery, pediatrics, and gynecology at Madison General and Methodist hospitals who coordinated the program. It was designed to give senior medical students an introduction to inpatient and outpatient medical practice.

The education committees of various Madison hospitals supervised the program which began July 1 and ended Sept. 8. The students were accepted on a competitive basis and awarded fellowship grants provided by the Dane County Medical Society, Jackson Clinic, Madison General Hospital, and Methodist Hospital.

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Wisconsin Surgical Society

Dr. Robert E. Condon of the Department of Surgery, University of Illinois, will be guest lecturer at the fall meeting of the Wisconsin Surgical Society Sept. 21 at St. Mary's Hospital in Madison. His subject is "Iatrogenic Problems in Surgery."

Other program participants are: Drs. *Walter R. Sundstrom*, Marion K. Ledbetter, *Eugene E. Skroch*, *Ronald C. Rudy*, *Richard J. Botham*, *George P. Steinmetz, Jr.*, *Paul O. Simenstad*, and *Frederick G. Joachim*, Madison; *W. Dudley Johnson*, Milwaukee; *Larry Carey*, Elm Grove; *John Riesch*, Menomonee Falls; and *Thomas Beno*, Green Bay. Resident papers were presented by Drs. *Louis Bernhard*, University Hospitals, Madison; George Reul, H. Harding, and Arthur Ames, Milwaukee County Hospital.

Featured speaker at the evening banquet, held at the Hoffman House East, was Donald Anderson, editor of the WISCONSIN STATE JOURNAL, who spoke on "Medicine and the Press."

Dr. John T. Mendenhall, president of the Society, will be host for the day. *Dr. Richard Botham* is chairman of local arrangements.

Wisconsin Academy of General Practice

The 20th annual scientific assembly of the Wisconsin Academy of General Practice will be held Sept. 25–26 in Milwaukee at the Pfister Hotel and Tower.

Panel participants on Premature Care, a joint program of the WAGP and the American College of Obstetrics and Gynecology, will be: Drs. *Stanley N. Graven*, Madison; John P. Grausz and Shimpei Sagaguchi, Milwaukee.

Other diversified subjects will be presented by Drs. Carl A. Whitaker, Madison; *E. E. Herzberger*, Monroe; *John B. Wear*, Madison; *Donald M. Ruch*, Milwaukee; *Allan J. Ryan*, Madison; *Gordon Davenport*, Madison.

Out-of-state guest lecturers will be Dr. Victor Gilbertson of Minneapolis and Dr. Philip Thorek of Chicago, Ill. Judge Richard W. Orton of Lancaster will deliver an address on "How Can the Family Physician Be of Help to the Family When a Juvenile Is in Trouble with the Law."

Moderators for the programs will be: *Drs. Richard W. Shropshire*, Madison; *Eugene Usow*, Milwaukee; and *S. L. Chojnacki*, Milwaukee.

Host for the event is *Dr. Norbert G. Bauch* of Milwaukee, president of the WAGP.

Wisconsin Society of Pathologists

The fall meeting of the Wisconsin Society of Pathologists will be held at the Marquette School of Medicine, Nov. 16, Milwaukee. There will be morning presentation of scientific papers by members and residents. There will be an afternoon tissue seminar from 1:30 to 4:30 on the subject, "Pathology of the Cardiovascular System." Moderator will be William C. Manion, Chief, Cardiac Pathology Branch, Armed Forces Institute of Pathology, Washington, D. C.

A meeting of the Board of Directors will be held at the Holiday Inn Central followed by the annual dinner and a business meeting.

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SECTION

OPHTHALMOLOGY

SEPTEMBER 1968

EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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ERNEST L. MacVICAR, JR., MD, 500 Walton Ave., Racine (Representative to American Association of Ophthalmology)

HERBERT GILLER, MD, 2040 W. Wisconsin Ave., Milwaukee (Section on Ophthalmology Representative to Opticianry)

E. J. ZEISS, MD, 1620 N. Meade St., Appleton (Section on Ophthalmology Representative to Commission on Public Policy)

ROBERT ANDREW, MD, 20 South Park Street, Madison

VOLUNTARY DUES ASSESSMENT

The Executive Committee reminds all Ophthalmologists that voluntary dues for the year 1968 are now being received. Voluntary contributions to the Section are used for projects specially designed to educate the public and others on medical eye care.

The regular voluntary membership contribution is $100. Educational membership contribution, for physicians who derive no part of their income from private practice, has been set at $50.

Please make your check payable to the Section on Ophthalmology and mail it to the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

UNIVERSITY OF WISCONSIN WINS AWARD

An exhibit on "Diabetic Retinopathy; a Clinical-histopathologic Correlation" by Matthew D. Davis, M.D., Guillermo de Venecia M.D., Ronald Engerman Ph.D., Frank Myers M.D., and Yvonne Magli, B.S., won the Certificate of Merit at the 117 Annual Convention of the A.M.A. at San Francisco in June 1968.

Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy. Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.[1]

*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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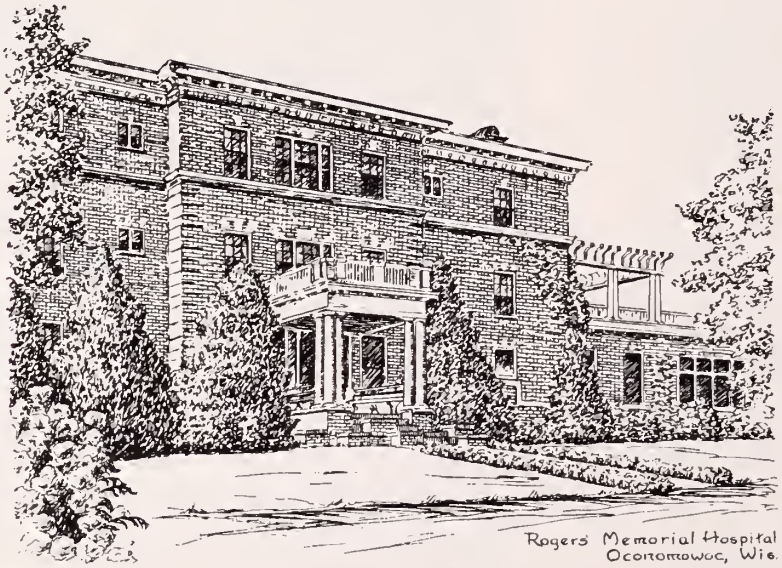

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Dr. Kalambaheti Joins Sparta Clinic

Dr. Kitti Kalambaheti, a native of Dhonburi, Thailand, recently joined the staff of the Sparta Clinic. He completed graduate study at the Siriraj Medical School and University of Medical Science at Bangkok in 1957. Doctor Kalambaheti interned at St. Elizabeth's Hospital, Milwaukee, and had residency training at Jersey City Medical Center. He was chief resident surgeon at Harlan Appalachian Hospital, Ky., was on the staff of the Kaiser Foundation Hospital, Honolulu, and Wyoming General Hospital. Doctor Kalambaheti is a board-qualified surgical specialist and has medical papers published in the AMERICAN JOURNAL OF SURGERY and the ARCHIVES OF SURGERY.

Dr. River Guest Speaker

Dr. George L. River of the Marshfield Clinic, and chief of staff at St. Joseph's Hospital, recently was the guest speaker at the Heart of Wisconsin (18th) District Nurses Association meeting in Marshfield. Doctor River spoke on "Emotional Support of the Dying Patient."

Dr. Headlee Reelected President

Dr. Raymond Headlee, Milwaukee, recently was reelected president of the medical staff of Milwaukee Psychiatric Hospital and *Dr. Philip Veenhuis* was named secretary-treasurer. Doctor Headlee is acting chairman of the department of psychiatry at Marquette School of Medicine.

Dr. Capelli Named Officer

Dr. Paul Capelli, Kenosha, recently was named treasurer of the Unified School Board in Kenosha. Doctor Capelli was elected for a three-year term.

Dr. Cooper Joins Marquette Faculty

Dr. Keith E. Cooper, chief of a medical research council unit at Oxford University for the last 10 years, has joined the Marquette medical school faculty for six months to help in research to find better ways of judging heart and blood vessel function. He is a fellow and tutor in physiology at St. Peter's College and a member of the editorial board of the JOURNAL OF PHYSIOLOGY and of the Physiology and Medical Research societies.

Doctors Sender and Brennan Guest Speakers

Drs. Neville Sender and *John Brennan*, Milwaukee, recently were the guest speakers at a meeting of the North Shore Democrats. Their subject was "Should Abortion Be Legalized?"

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Deardorff Receives Research Grant

Dr. William L. Deardorff, Elm Grove, recently began a year's study at Emory University's medical school in Atlanta, Ga., on a research government grant. He is one of 81 specialists who will be trained in the prevention, diagnosis, and treatment of cancer in a program of the National Center for Chronic Disease Control, a division of the Public Health Service.

Dr. Carey Returns to Marquette Faculty

Dr. Larry C. Carey, Elm Grove, recently returned to the faculty of the division of surgery at the Marquette School of Medicine. He has been with the United States Navy Medical Corps serving at Chelsea Naval Hospital, Mass., and at the Naval Station hospital, Da Nang South Vietnam.

Dr. Clarke Leaves Clinic

Dr. G. S. Clarke, a member of the Chetek Clinic recently left the clinic for specialized radiology training. He is being replaced by Dr. Joseph P. Bender, Sandstone, Minn. Dr. David Pierpoint, Minneapolis, is also joining the Clinic. He graduated from the University of Wisconsin Medical School and interned at St. Mary's Hospital, Duluth.

Dr. Handy Named Diplomate

Dr. George H. Handy, Madison, assistant state health officer, recently was named a diplomate of the American Board of Preventive Medicine and has been certified by that board as a specialist in public health. Certification by the board makes him eligible for fellowship in the American College of Preventive Medicine.

Dr. Barreto Coauthor of Book

Dr. Reinaldo Barreto, Kenosha, is coauthor of a recent publication entitled "Palliative Care of the Cancer Patient." He was named director of the Department of Anesthesiology and Inhalation Therapy at Memorial Hospital, Kenosha, in 1967 and has previously served as associate professor of anesthesiology at Marquette University and the University of Wisconsin.

Named Head Start Medical Advisor

Dr. Marwood E. Wegner, St. Croix Falls, recently was named to the duties of Regional Medical Consultant to Head Start programs operating under the agency's jurisdiction within the following seven counties: Barron, Chippewa, Dunn, Pierce, Polk, Pepin, and St. Croix. Doctor Wegner will be advissing the health personnel in the medical aspects of the program.

Dr. Morgan Receives Certification

Dr. S. F. Morgan, Whitefish Bay, recently received a certificate of appreciation in recognition of his 34 years of service to the Whitefish Bay community. He became deputy health commissioner in 1934 and health commissioner in 1946.

Dr. Brandenburg Heads Otolaryngology

Dr. James H. Brandenburg succeeded *Dr. Maxine Bennett* July 1 as chairman of the division of otolaryngology at the University of Wisconsin Medical School. Doctor Bennett plans to do special research work.

Dr. Blahnik At Washington University

Dr. C. L. Blahnik, formerly of Peshtigo, who had been training in Ophthalmology at Charity Hospital in New Orleans, is now a fellow on the retina service at Washington University in St. Louis, Mo. He is working under Dr. Edward Okun doing research using photocoagulation in diabetic retinopathy and also is associated with the retinal detachment surgical unit.

Dr. Schroeder New Clinic Head

Dr. Daniel J. Schroeder, Amery, recently was named president of the Board of Directors of Barron–Polk Guidance Clinic. The Guidance Clinic serves Barron, Burnett, Polk, and Washburn counties with offices and headquarters presently located in Turtle Lake.

Dr. Orman Heads Guidance Clinic

Dr. Edward S. Orman, Madison child psychiatrist, recently was hired as the first full-time medical director of the La Crosse County Guidance Clinic. Following internship in Mount Sinai Hospital and residency in internal medicine in Milwaukee County General Hospital, Doctor Orman also had residencies in psychiatry, including child, at the UW University Hospitals, Madison. In 1963 and 1964, Doctor Orman was staff psychiatrist at the Wisconsin School for Boys at Wales. He had been consultant to the Milwaukee public school system and to groups in Dane, Grant, and Columbia counties. Since 1966, he has been chief of service at the Wisconsin Children's Treatment Center, Madison.

Doctors Begin Internships at Clinic

A staff of eight interns has begun a year of training at the Gundersen Clinic Ltd. and La Crosse Lutheran Hospital, La Crosse. *Dr. Kermit Newcomer*, a member of the Gundersen Clinic staff is in charge of the internship program. The interns are: Drs. Thomas N. Roberts, Norman F. Deffner, James K. Williams, L. Douglas Oss, Gordon L. Johnson, Jerry Kreiter, Clyde C. Lawnicki, and Egil Fossl'en.

Dr. Kubiak Featured in Newspaper

Dr. Mary Kubiak, Oshkosh, recently was featured in the OSHKOSH PAPER, for completing 13 years as a staff physician at Winnebago State Hospital. Doctor Kubiak treats mentally ill patients at Winnebago State Hospital and Winnebago County Hospital besides being a mother and housewife to five children. She graduated from the University of Wisconsin Medical School and interned at Mercy Hospital, Oshkosh.

Doctors Added to Marshfield Clinic

The Marshfield Clinic recently added five more doctors to its staff. They are: Drs. Robert F. Mack, Robert D. Carlson, Robert H. Winemiller, Charles P. Floyd, and *George M. Sparks*.

Doctor Mack graduated from the University of Minnesota and took his internship and residency work at St. Mary's, Duluth, in Pathology. Doctor Carlson graduated from Medical School at Temple University, Philadelphia, and interned at Marion County Hospital, Indianapolis, Ind. He was with the Public Health Service in North Dakota and Minnesota and then returned to Temple to complete his residency in Radiology. Doctor Winemiller, a specialist in Internal Medicine with subspecialties in kidney diseases and hypertension, graduated from De Pauw University of Chicago Medical School and did residency training at the Cleveland Clinic. He served two years in the United States Army Medical Corps.

Doctor Floyd graduated from the University of Michigan in 1958, interned in Denver, Colo., and served three years in the United States Army Medical Corps. He took his residency training at the University of Utah and recently completed two years of residency, in general surgery, at Grady Memorial Hospital, Atlanta, Ga.

Doctor Sparks, specializing in Ophthalmology, graduated from the Illinois College of Medicine, Chicago, and interned at Torgas Hospital, Canal Zone. He spent his residency at the Illinois Eye and Ear Infirmary, Chicago, and has been associated with the United States Public Health Service in Madison for the last two years.

Dr. Gold Joins Beloit Clinic

Dr. Kenneth I. Gold, New York, recently joined the staff of the Beloit Clinic. Doctor Gold graduated from State University of New York, Brooklyn, in 1961 and completed his internship at University Hospitals, Columbus, Ohio. He did residency work in internal medicine before entering the United States Navy in 1963. He recently completed a two-year fellowship in psychosomatic medicine and cardiology in the Medical–Psychiatric Liaison Group at the University of Rochester School of Medicine, New York. He also served as an instructor and fellow at the school.

Physicians Locate in Wisconsin

Four physicians who have been in residency at the Mayo Graduate School of Medicine, University of Minnesota, Rochester, have now located in Wisconsin. They are: Dr. B. K. Stambuk, specialist in Hematology, and Dr. F. S. Brightbill, specialist in Internal Medicine, who will be located in Madison; *Dr. J. L. Windeck*, Internal Medicine, in Chippewa Falls, and Dr. J. W. Faber, Dermatology, in Neenah.

Doctor Burrows Joins Riverside Clinic

Dr. Thomas H. Burrows, a specialist in diseases of the ear, nose and throat, recently joined the staff of the Riverside Clinic, Menasha. He graduated from Johns Hopkins University, Baltimore, Md., and interned at Henry Ford Hospital, Detroit. His residency work was taken at Johns Hopkins Hospital from 1963 to 1968.

Physicians Join Woodstock Medical Group

Drs. Robert Foresman and *Stephen Propeck* recently joined the staff of the Kishwaukee Valley Medical group. Both have completed military service and Doctor Propeck has recently completed work at Milwaukee County General Hospital and Doctor Foresman has been a fellow at the cardiopulmonary laboratory of the Veterans Administration Hospital, Hines, Ill.

Dr. Johnson Associates with Midelfart Clinic

Dr. Daniel F. Johnson, Madison, recently became associated with the staff of the Midelfart Clinic, Eau Claire. He graduated from Washington University, St. Louis, Mo., and interned at the Jewish Hospital, St. Louis. The past five years, Doctor Johnson has been at University Hospitals, Madison, where he completed his residency in obstetrics and gynecology. He served in the United States Navy from 1962–1964.

Dr. Hearn Joins the Wilkinson Clinic

Dr. Richard F. Hearn recently joined the staff of the Wilkinson Clinic, Oconomowoc. Doctor Hearn served in the United States Army from 1956 to 1958 and taught school at Loras College, Dubuque, Iowa. He graduated from Marquette University School of Medicine and interned at Misericordia Hospital. Doctor Hearn was in general practice in West Bend from 1963–1964 and took his residency work at St. Joseph's Hospital, Milwaukee, from 1964–1968 in general surgery.

Dr. Jahn Returns to Quisling Clinic

Dr. Charles Jahn recently returned to the Quisling Clinic in Madison after serving two years with the United States Naval Hospital in Jacksonville, Fla. Doctor Jahn graduated from the University of Wisconsin Medical School and interned at Children's Orthopedic Hospital, Seattle, Wash. He took his pediatric residency at University Hospitals, Madison.

WISCONSIN CHEESE FOR DU PONT KIN—*Dr. Robert G. Zach* of The Monroe Clinic presented F. I. du Pont II, left, of the well-known American corporation, with a gift of Green County Swiss cheese following Mr. du Pont's talk in Monroe this summer. Mr. du Pont of Niles, Ill., a sixth great-grandson of the founder of E. I. du Pont de Nemours Co. spoke to staff members of The Monroe Clinic about the many facets of the du Pont company including its contributions to medicine. He also was interested in the use Doctor Zach has made of a plastic composition, produced by his company, in the handcrafting of unique jewelry held in Mr. du Pont's left hand.

Dr. Callan Talks of Future

Dr. Robert E. Callan, president-elect of the State Medical Society, voiced his concern about the future of medicine when he addressed the 22nd quarterly meeting of the Hospital Area Planning Committee at the Milwaukee Inn August 2. He said government control of medical practice remains the No. 1 fear of private physicians. Doctor Callan also expressed his concern of "the seemingly inevitable development of hospital-based health care."

He mentioned the anxieties of doctors when they read a report in THE MILWAUKEE JOURNAL last October quoting Ray E. Brown, Boston, chief of Harvard University's Associated Hospitals. Mr. Brown said that patients should be able to join a hospital as they now join a church. Doctor Callan noted that hospital-based care is expensive and threatens free choice of physician and the fee-for-service method of paying doctors.

But, despite these concerns, Doctor Callan said he was advising Wisconsin doctors to compromise as social change occurs to try to preserve what they want most.

Dr. Myers Joins Marshfield Clinic

Dr. William O. Myers recently joined the staff of the Marshfield Clinic. Doctor Myers graduated from Northwestern University Medical School in 1955 and interned at City of Detroit Receiving Hospital. He served his residency there and entered the

Christmas Cards

CHRISTMAS DINNER AT THE SURGEONS QUARTERS

"Christmas in the Surgeons Quarters at Fort Winnebago was a festive scene as military custom in the early 19th century permitted officers' families to live on post. The Christmas board included beef or venison, rabbit or wild duck, wild rice, native nuts and fruit pie. Even the traditional tree and gifts were there. Today, near Portage, the Surgeons Quarters stand nearly as they did 150 years ago — now restored and operated by the Wisconsin Society, Daughters of the American Revolution."

A Special Project of the Women's Auxiliary TO THE STATE MEDICAL SOCIETY

Proceeds will support special projects as designated by the Woman's Auxiliary.

Box of 25 **$3.75** NAME IMPRINTED ON REQUEST (at an additional cost)

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Woman's Auxiliary to the State Medical Society of Wisconsin Box 1109, Madison, Wis. 53701

Be sure to include quantity desired and the name to be imprinted if desired.

PHYSICIAN NEWS *continued*

United States Air Force. He went to general practice in Blue Hill, Neb., and then was a resident in general surgery at Sacred Heart Hospital, Yankton, S.D. In 1966, he was a resident in general surgery at the University of Kansas Medical Center and the following two years were spent in residency in thoracic and cardiovascular surgery, which is his specialty now.

Doctor Link Joins La Crosse Clinic Ltd.

Doctor Charles Link, Waukon, Iowa, joined the staff of the La Crosse Clinic Ltd. He graduated from Marquette University School of Medicine and completed his internship at Lutheran Hospital, Milwaukee. He served in the United States Army Medical Corps and took his residency work at Milwaukee County General Hospital.

Doctor Engel Joins Salem Clinic

Dr. Charles Engel recently joined the staff of the West Salem Clinic in the practice of general medicine. He graduated from the University of Wisconsin Medical School and interned at Lutheran Hospital, La Crosse. He served in the United States Army and taught preventive medicine at the medical field service school. Doctor Engel took his residency at Lutheran Hospital, La Crosse, following his tour of duty in the service.

Dr. D'Elia Associates with Dr. Baertsch

Dr. Rudolph D'Elia, East Hazel Crest, Ill., recently became associated with Dr. L. M. Baertsch, Hayward. A practicing surgeon since 1937, Doctor D'Elia graduated from the Chicago Medical School and served his internship at Binghamton City General Hospital. He was a resident in surgery at Stetson Hospital in Philadelphia, Pa. Doctor D'Elia founded the Hazel Crest Hospital in 1940 and was founder-designer of the Hazel Crest General Hospital in 1946. He has served as a surgeon for the Illinois Central Railroad and has authored several medical articles.

Pediatric Resident Awarded Fellowship

A University of Wisconsin pediatric resident, Dr. Edward B. McCabe, Madison, is recipient of a Wyeth Fund award of $4800 toward the expenses of undertaking advanced training in the medical care of children. The two-year residency fellowship in Pediatrics commenced July 1 and is one of 15 such grants given this year by the Wyeth Fund for Postgraduate Education.

* * *

WIDOWS OF VETERANS of all wars on the pension rolls of the Veterans Administration, who are blind or helpless enough to require regular aid and attendance, or who are patients in nursing homes, are entitled to receive $50 a month more than their regular pension payment.

Wisconsin Regional Medical Program

Dr. Warren Cole was the keynote speaker at the Regional Advisory Committee of the Wisconsin Regional Medical Program July 27. A Past President of the American Cancer Society and Professor Emeritus of Surgery at the University of Illinois, Doctor Cole discussed "The Cooperative Project of the American College of Surgeons and the Division of Regional Medical Programs."

A feature of the day-long WRMP meeting at Wingspread, the conference center of the Johnson Foundation, was the participation of the program coordinators and chairmen of the Regional Advisory Committees of the Illinois, Iowa, Michigan, and Northlands Regional Medical Programs. The presidents and chief executives of the Wisconsin Divisions of the Cancer Society, the Heart Association, and the Anti-Tuberculosis Association were invited as guests of WRMP at Wingspread.

Dr. John S. Hirschboeck, coordinator of the Wisconsin Regional Medical Program, reported on the First Annual Meeting of WRMP committees and study groups. The conference agenda also included a review of proposals from study groups for possible operational projects.

Doctors Hospital Opens Emergency Department

Doctors Hospital, Milwaukee, officially opened its new Emergency Department July 1, according to Walter G. Harden, Administrator. The Emergency Department, a community service, is being fully staffed 24 hours a day, with a physician in constant attendance. It is a part of the new hospital building at Doctors Hospital, completely equipped to handle emergency care.

Marquette Given $250,000 Grant

Marquette School of Medicine is one of 30 private medical schools in the nation who is sharing in a $10 million grant from the Richard King Mellon Charitable Trusts, Pittsburgh, Pa., to expand and strengthen their permanent faculty staffs.

Marquette will receive $50,000 each year for the next five years. Selection was made on the combined basis of need, demonstrated excellence, and location.

The monies are to be spent according to each school's needs for faculty recruitment, but with emphasis on attracting young people into careers in the basic medical sciences which comprise the first two years of medical school education.

The $10 million gift makes a total of slightly more than $57 million that has been contributed to medicine through grants and gifts by Lieutenant General and Mrs. Richard King Mellon since 1945, including $6,350,000 given for medical school faculty salaries in 1963–67. General Mellon, Pittsburgh financier, is a Governor and President of T. Mellon & Sons, investment management firm.

Research Grant, Milwaukee Blood Center

The National Blood Resource Program of the National Heart Institute, National Institutes of Health, has awarded $184,000 to the Milwaukee Blood Center for studies on the feasibility of a computer-based regional or national inventory system for whole blood, blood products, and blood donors.

Cancer Research Awards Granted

Four more cancer research grants totaling $37,542 were awarded to Milwaukee scientists by the Milwaukee division of the American Cancer Society, according to an announcement by *Dr. L. J. Van Hecke*, division chairman. Doctor Van Hecke added that these grants brought to $90,540 the total of research money provided 11 local scientists by the cancer society during the past year.

Recipients of the latest research grants are: *Dr. Mortimer M. Bortin*, Associate Clinical Professor of Medicine, Mt. Sinai Hospital, $8,186; Dr. Sidney E. Grossberg, Professor and Chairman, Department of Microbiology, Marquette School of Medicine, $10,000; Dr. Wei Y. Huang, Assistant Professor of Gynecology and Obstetrics, Marquette School of Medicine, $8,340 and Dr. Thomas A. Good, Associate Professor of Pediatrics, Marquette School of Medicine, $11,016.

Doctor Van Hecke pointed out that the grants were approved by the cancer society's medical and scientific committee of which *Dr. James E. Conley* is chairman.

New Method for Lab Test

The Pathology Department of Doctors Hospital is the first in a private hospital in the area to use a new clinical method for testing the sensitivity of bacteria to antibiotics, according to *Dr. Robert Lipo*, Chief of Pathology.

The new method is not only accurate, but also rapid and comparatively inexpensive. It was developed by a working group of the World Health Organization, operating under the United Nations, of which Silas G. Farmer, PhD, microbiologist at Milwaukee County General Hospital, is a member.

The Expert Committee on Antibiotics and Chemotherapy, as the working group is called, is composed of 12 doctors from eight countries under the chairmanship of Dr. Hans Ericsson of Sweden. It has been at work since 1964.

Through its work, the committee has been able to give rapid, reliable quantitative information for the use of antibiotics by determining the relation

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Physicians whose names appear in italics are members of the State Medical Society.

Annual Convention

WISCONSIN NURSES ASSOCIATION

Oct. 9–11—Milwaukee

SHERATON–SCHROEDER HOTEL

Theme: *Sharing the Caring*

Distinguished Guests and Their Topics

JESSIE M. SCOTT, RN

Newly elected second vice-president of the American Nurses Association; and Director of Division of Nursing, Department of Health, Education and Welfare, Arlington, Va.

Nursing Resources Today—Projections for Tomorrow

JAMES DE MARCO, RN

Director of Nursing, Children's Hospital of Akron, Ohio

Automation and Nursing

Followed by a reactor panel of officials from three Wisconsin hospitals and a representative of IBM.

FRANK E. X. DANCE, PhD

Director of Speech Communication Center, University of Wisconsin–Milwaukee

Interdisciplinary Communications for Sharing the Caring

ELEANOR C. LAMBERTSEN, RN

Director, Division of Nursing Education, Teachers College, Columbia University, New York

How to Change the Unchanging Nurse

INEZ HINSVARK, RN

Dean, School of Nursing, University of Wisconsin–Milwaukee

Forum on Nursing Education

Seven nursing clinics to run concurrently on Thursday, Oct. 10. Subjects include: nursing care plans, family planning services, interdependence of nursing service and nursing education, alcoholism, staff development through inservice programs, nursing care of the monitored cardiovascular patient, and venereal disease nursing.

WNA Special Committee to Develop a Nursing Service Guide for Nursing Care in Nursing Homes will hold organizational meeting for a Conference Group on Geriatric Nursing Practice on Thursday evening, Oct. 10. To give impetus to the new group, a lecture will be given by

MRS. DOROTHY J. HUTCHISON, RN

Nursing Specialist, University of Wisconsin Extension, Department of Nursing, Madison

Operation Impact

(continued in adjacent column)

between the amount of antibiotic used and the size of the zone of its effectiveness.

A report of the progress of the committee will be given at a meeting of the World Health Organization in Berne, Switzerland, in the fall of 1968.

Medical Library Grant to La Crosse Hospital

St. Francis Hospital has been awarded a Medical Library Resource Grant by the United States Department of Health, Education and Welfare. The grant, the second in as many years, will be used in the acquisition of library materials to add to the psychiatric, neurological, and surgical sections of the library, according to Medical Librarian Sister M. Audrey.

British Scientist Joins Marquette Staff

A British physician, internationally known for his work on body temperature regulation and blood circulation, has joined the staff of Marquette School of Medicine for six months. Dr. Keith E. Cooper will be a visiting professor of physiology until January 1st and is expected to assist in setting up a new large scale research program to evaluate heart and blood circulation functions.

Doctor Cooper is here under a new fellowship program started this year by the National Science Foundation to support the visits of senior foreign scientists to approximately 50 schools in the nation. They are selected on their ability to contribute to research and teaching programs. Doctor Cooper's fellowship was obtained for the physiology depart-

(continued from adjacent column)

Also on Thursday evening, Oct. 10, the

CONFERENCE GROUP ON PSYCHIATRIC NURSING PRACTICE

will hear a team of professional staff members from the Veterans Administration Hospital, Wood, speak on

Attitude Therapy

OPERATING ROOM NURSES CONFERENCE GROUP

will meet at Sheraton–Schroeder Hotel Saturday, Oct. 12.

Speakers include: MRS. MYRTLE D. AISSEN, RN, Green Bay, and BEATRICE K. PALEN, RN, Madison, giving a progress report on surgical technician training programs; ELEANOR LAMBERTSEN, RN, New York, *Teamwork in Caring for the Surgical Patient*, and PAUL A. JACOBS, MD, Milwaukee orthopedic surgeon, on *Compression Plate Technique.*

ALL WISCONSIN NURSES, regardless of membership in WNA, are welcome to all convention programs

Customary, Usual and Reasonable . . .

In a breakthrough that startled many in the insurance world, the State Medical Society of Wisconsin through its insurance division, WPS–Blue Shield, inaugurated the "customary, usual and reasonable" concept in its insurance policies in 1955.

Today, this approach is used by many insurance plans. It is the key payment mechanism in Medicare and Medicaid as well as other government funded programs. It is being considered as a national "standard" for all Blue Shield plans in the nation.

Since it is so widely used, and its proper application so crucial to the future of voluntary insurance, it may serve all concerned to reprint the original expression of philosophy as to the operation of "customary, usual and reasonable:"

"Under the WPS Special Service contract the county medical society assumes its rightful role as counselor, fact-finder, arbiter, and reporter in handling Blue Shield claims at the place where they are incurred.

"The Special Service contract provides that most benefits will be paid to the extent of the physicians' customary, usual and reasonable charges. A charge will de deemed customary, usual and reasonable if it does not exceed the general level of charges by others who render such services or dispense such materials under similar or comparable circumstances within the community in which the charge is incurred.

"WPS–Blue Shield expects that physicians submitting claims for patients holding the Special Service contract will do so on the basis of their usual charges, considering the patient's medical condition, the scope of service rendered, skill required, length of period of care, income, age, and the like. Processing of claims on this basis of necessity requires a complete description of services rendered.

"Where the Special Service contract is sold the county medical society is asked to form an insurance advisory committee to assist the WPS–Blue Shield office in the evaluation of claims. The vast majority of claims can be processed promptly by the WPS–Blue Shield office. Those involving unusual service, complicated and prolonged care, or involved circumstances may require referral to the county advisory committee. Referral of such a claim does not imply that it is "unreasonable" or that it contains elements of overcharge. Ordinarily, such claims simply require more serious consideration to assure adequate and fair settlement. Some need added description and explanation from the physician in charge before proper payment can be made.

"Among the elements ordinarily considered in determining the customary, usual and reasonable charge are:

1. The difficulty of rendering the services.
2. Skill required in the performance of the services.
3. The experience and skill of the person furnishing the service.
4. The range for charges for such services under all circumstances.
5. Any agreements as to charges which might have been made with the patient.
6. The necessity for consultants or assistants.
7. The necessity as to type and extent of laboratory work.
8. The necessity of medications, x-rays and prosthetic devices.
9. The financial ability of the patient to pay.
10. The general level of similar charges for services or materials in the community or area in which the charge is incurred.

"These are factors which can best be evaluated by the county society among its own members."

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2 strains
3 contusions
4 lacerations
5 postoperative
6 fractures
7 bruises
8 sprains

MADLAND

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ment of the medical school through the Marquette University Graduate School. Doctor Cooper is a fellow and tutor in physiology at St. Peter's College, Oxford University, Oxford, England.

Dr. James J. Smith, Chairman of physiology at the medical school, indicates that Doctor Cooper will consult with several departments of the medical school and the university to help correlate a newly formed joint research effort to find better criteria for assessing cardiovascular function. The departments involved in the medical school will be physiology, medicine, neuropharmacology, and psychiatry and in the university, biology, psychology, and engineering.

Assignment in Washington, D.C.

Edward J. Connors, superintendent of University Hospitals, Madison, on Sept. 1 started a one-year assignment as consultant to the Health Services and Mental Health Administration, Department of HEW, Washington, D.C.

Mr. Connors, in his advisory capacity, will be working primarily on the future of Hill–Burton health facility building fund legislation, and with the newly established Center for Health Services Research. He will represent the field of hospital administration at the Center.

Marquette Given Funds to Build Lung

Scientists of Marquette School of Medicine have received a $35,000 grant to develop a human model of the artificial lung which they have tested successfully on dogs. The money was awarded by the John A. Hartford Foundation to Dr. Richard D. Stewart and Edward D. Baretta. Doctor Stewart is an associate professor and is chairman of the department of environmental medicine at Marquette. Mr. Baretta is a research engineer. Both came to Marquette two years ago from Dow Chemical Co., Midland, Mich., where they had been developing a new type of artificial kidney.

Hospital Retains X-Ray School Graduates

An unusual feature of the three-member graduating class of the Doctors Hospital X-ray School, Milwaukee, is that all the graduates will remain with the hospital to begin their careers as Registered Radiologic Technologists.

Graduating July 12, after a two-year course of study, are Mary Frisvold and Julie Frankwick, Milwaukee and Mary Sydow, Brown Deer.

Dr. Leo Stockland, Bayside, head of the x-ray school, has announced that the school has been increased in size. Formerly seven students were in attendance; there will now be 10.

* * *

THE FULL REASONABLE charges for x-ray and laboratory services are now covered under Medicare for bed patients in hospitals who have both hospital and medical insurance.

OBITUARIES

Dr. Francis D. Murphy, 72, Wauwatosa, died June 15, 1968, in Wauwatosa.

Doctor Murphy, nationally recognized authority on kidney diseases, graduated from the Marquette University School of Medicine in 1920 and also received a degree in medicine from the University of Pennsylvania. In 1924, he became assistant medical director at Milwaukee County General Hospital and in 1926, director. Doctor Murphy received a certificate of Honor in 1933 for his exhibit on kidney diseases at the American Medical Association convention. In 1958, he retired from the chairmanship of the department of medicine at Marquette University and the directorship of Milwaukee County General Hospital whose library was named the Francis D. Murphy Library in 1959. He was chief of staff at St. Joseph's Hospital from 1936 until 1942 and again from 1947 to 1954. In 1955, a $100,000 research fund was established in his name by an industrialist and an endowment of $350,000 given to the Marquette University School of Medicine in 1957 to create the Francis D. Murphy chair of medicine. Doctor Murphy received the medical school's Alumnus award in 1952, the Marquette University Alumnus award in 1956, and an honorary Doctor of Laws degree from MU in 1961.

Doctor Murphy was a charter member of the Central Society for Clinical Research, American Foundation for High Blood Pressure, Milwaukee and Wisconsin societies of Internal Medicine; honorary member of the American College of Dentists and Mississippi Valley Medical Society; and a life member of the Milwaukee Academy of Medicine.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

He also held memberships in the national organizations of Physicians, Cardiology, Therapeutic, Diabetic, Heart, Advancement of Science, Geriatrics, Study of Arteriosclerosis, and Railway Surgeons. He was a member of the Chicago Society of Internal Medicine, Milwaukee Surgical Society, and Wisconsin Historical Society.

Surviving are his widow, Madaline; a son, Dr. Francis D. Murphy, Jr., San Francisco, Calif.; and a daughter, Mrs. Thomas Foley, Wauwatosa.

Dr. Rowe G. Baker, 67, Tomahawk, died June 19, 1968, in Tomahawk.

Doctor Baker graduated from Rush Medical College, Chicago, in 1927 and interned at Oak Park, Ill. He served as Tomahawk's health officer for over 25 years and in 1965 he received a citation for over 20 years of service with the Selective Service system as a medical advisor.

He was on the staff of the Sacred Heart Hospital, Tomahawk, a member of the American Society of Abdominal Surgeons, the Wisconsin Society of Obstetrics and Gynecology, the American Society of Railway Surgeons, and the Wisconsin Medical Alumni Association. Doctor Baker served as a delegate to the State Medical Society of Wisconsin in 1951, and was a member of the Lincoln County Medical Society, and American Medical Association.

Surviving is a daughter, Mrs. Robert Wilson, Houston, Tex.

Dr. Ira M. Bemis, 67, Batavia physician for 41 years, died June 21, 1968, in Sheboygan.

Doctor Bemis graduated from the Marquette University School of Medicine in 1927 and interned at St. Elizabeth's Hospital, Appleton. He was a lifelong resident of the Batavia community and served as its health officer for 41 years.

He was a member of the Sheboygan County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Lona, and two sons, Eugene and Richard, Batavia.

Dr. Warren T. Hagerty, 65, well known Green Bay physician, died July 1, 1968, in Green Bay.

Doctor Hagerty graduated from the University of Marquette School of Medicine in 1928 and interned at St. Joseph's Hospital in St. Paul, Minn. He practiced in Spooner for several years and then returned to Green Bay in 1932.

Doctor Hagerty was a member of the Brown County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Evangeline; a son, Michael, and a daughter, Patricia, Green Bay.

Dr. Charles C. Davin, 75, Kenosha physician for 48 years, died July 25, 1968, in Kenosha.

Doctor Davin graduated from Vanderbilt University School of Medicine, Nashville, Tenn., in 1916. He interned at City Hospital, Nashville, and did postgraduate work at the Chicago Eye, Ear, Nose and Throat College. Before entering service in World War I, Doctor Davin practiced for a short time in Weyerheuser, Wis. He served Kenosha as the school physician and was also the Assistant Director of Health from 1929 to 1952. Doctor Davin was on the medical staff of Kenosha Memorial Hospital and St. Catherine's Hospital. He was chief of staff at St. Catherine's for one year. Doctor Davin was elected into the Fifty-Year Club of the State Medical Society of Wisconsin in 1966.

Doctor Davin was a member and past president of the Kenosha County Medical Society, a member of the State Medical Society of Wisconsin, and American Medical Association.

Surviving is his widow, Margaret. He was preceded in death by a son and daughter.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF JULY 22, 1968

NEW MEMBERS

Banaszak, Edward F., 6745 West Wells St., Milwaukee 53213
Burg, Edward A., Jr., 3321 North Maryland Ave., Milwaukee 53211
Fetherston, Thomas J., 6900 North Port Washington Rd., Milwaukee 53217
Fine, Stuart W., 2110 East Glendale Ave., Milwaukee 53211
Gabriel, Reynaldo P., P. O. Box 220, Wausaukee 54177
Geretti, Roland J., 3039 South 82nd St., Milwaukee 53219
Hussey, Clara V., 8700 West Wisconsin Ave., Milwaukee 53226
Kalambaheti, Kitti, 202 K St., Sparta 54656
Kenny, John Andrew, 1176 East Walnut St., Green Bay 54301
Lichty, James E., 2200 West Kilbourn Ave., Milwaukee 53233
Magnin, Dean, 1510 Main St., Marinette 54143
Pinkerton, John D., 516 Houston St., Marinette 54143
Short, Howard W., 5625 Washington Ave., Racine 53406
Yasatan, Nasip H., 1130 Coronada Dr., Racine 53402
Zarem, Norton L., 312 East Wisconsin Ave., Milwaukee 53202

CHANGES OF ADDRESS

Ali, Masroor, Reedsburg, to Waupun Clinic, Waupun 53963
Alt, Thomas H. U.S.A. Disp. Mainz, APO New York, N.Y. 09185
Aprahamian, Charles, West Allis, to Krohn Clinic, Black River Falls 54615
Blahnik, Clarence L., Gretna, La., to 660 Euclid Ave., St. Louis, Mo. 63110
Barbo, Dorothy Marie, Stoney Point, N.Y., to Hammond 54015
Blanchard, H. H., Mequon, to 523 Thomaston St., Barnesville, Ga. 30204
Bukosky, Richard J., New Berlin, to 926 N. Wood Ave., Linden, N.J. 07036
Carlsson, Edward S., 346 Losey Blvd. S., La Crosse 54601
Clark, Ralph A., New Berlin, to Woodhull, Ill. 61490
Crottier, C. J., 2735 South 46th St., Milwaukee 53219
Cullen, Robert E., 527 East Division St., Fond du Lac 54935
Datka, Gordon L., Indianapolis, Ind., to 5310 South 43rd St., Milwaukee 53220
Deardorff, William L., Wauwatosa, to 428 Princeton Way, Atlanta, Ga. 30307
Debus, Elmer E., 311 Third Ave., South, Wisconsin Rapids 54494
Dehne, Kurt G., Milwaukee, to 5500 Schluter Rd., Monona Village 53716
Dortzbach, Richard K., 1300 University Ave., Madison 53706
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Gager, Walter E., Key Biscayne, Fla., to 3820 N. Newhall Ave., Shorewood 53211
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Geitz, Marten, Marshfield, to 513 W. Fourth St., Odessa, Tex. 79760
Gerndt, H. L., Jr., Manitowoc, to 628 Thomas St., Fort Levenworth, Kan. 66027
Gilmor, Richard L., Milwaukee, to 3335 Watergate Rd., Indianapolis, Ind. 46224
Gottlieb, A. M., Madison, to V. A. Hospital, 3801 Junipero Serra Blvd., Palo Alto, Calif. 94304
Harned, Roger K., Charlottesville, Va., to Monroe Clinic, Monroe 53566
Hermundstad, Orin A., Stoughton, to 1300 University Ave., Madison 53706
Hill, Ben S., 7736 3rd Ave., Kenosha 53140
Horswill, C. Weir, 4810 Fond du Lac Trail, Madison 53705
Jacobs, Edmund B., Jr., Madison, to David Grant USAF Hospital MAC, Travis AFB, Fairfield, Calif. 94535
Jahn, Charles L., Jacksonville, Fla., to 2 West Gorham St., Madison 53703
Janssen, Martin L., Adams, to P. O. Box 10, Friendship 53934
Joseph Leo G., 1521 South 31st Place, La Crosse 54601
Klasinski, C. A., Warren, Mich., to 529 Division St., Stevens Point 54481
Klutzow, F. W., Gillett, to 488 Presidential Lane, Madison 53711
Kowalski, Thomas H., Greendale, to 5757 West Oklahoma Ave., Milwaukee 53219
Koch, C. B., New Lisbon, to 1162 South Willamette St., Eugene, Ore. 97401
Kratochvil, Clyde H., Holloman AFB, New Mexico, to 3814 Leatherwood Place, Dayton, Ohio 45424
Kreitzer, Frank V., 9415 West Wisconsin Ave., Milwaukee 53226
Maas, David A., Webster, to 1011 South Tracy, Bozeman, Mont. 59715
Marnocha, John R., 1176 East Walnut St., Green Bay 54301
Martens, Thomas J., APO San Francisco, Calif., to 1121 Sawmill Gulch, Pebble Beach, Calif. 93953
McCabe, John, Milwaukee, to 1122 Colorado St., Austin, Tex. 78701
Milliken, Lyle D., Jr., 7735 5th Ave., Kenosha 53140
Milson, Stuart E., APO San Francisco, Calif., to 505 South Military Ave., Green Bay 54303
Miner, Harold B., 1226 West Wisconsin Ave., Milwaukee 53233
Oberfeld, Harold H., Miami Beach, Fla., to 3909 N. Murray Ave., Milwaukee 53211
Peterman, M. G., Leesburg, Va., to 1962 N. Prospect Ave., Milwaukee 53202
Pinell, Octavio C., Granada Hills, Calif., to 1414 26th St., N.W., Rochester, Minn. 55901
Plautz, Arthur C., Ft. Campbell, Ky., to 2414 Ruger Ave., Janesville 53545
Rafiullah, Mahammed, 5120 Darby Place, Racine 53402
Rahn, Bruno F., Route 6, Box 162, Chippewa Falls 54729
Ramin, James E., 6001 West Center St., Milwaukee 53210
Richany, Shafik F., Columbia, Mo., to 1009 Woodlawn Park Drive, Flint, Mich. 48503
Schatzki, Peter F., Houston, Tex., to Medical College of Virginia, Richmond, Va. 23219
Schlichting, Johanna E., St. Paul, Minn., to P. O. Box 971, Fond du Lac 54935
Schoeneman, Robert H., Butler, to 2420 North 94th St., Wauwatosa 53226
Schroder, John R., 2020 East Milwaukee, Janesville 53545

Shapson, Milton, Suite 1227, 208 E. Wisconsin Ave., Milwaukee 53202
Shumate, John K., 2013 Carver Rd., Madison 53713
Slotnik, Irvin L., Miami, Fla., to 950 N. 35th St., Milwaukee 53208
Sparks, George M., Middleton, to Marshfield Clinic, Marshfield 54449
Spence, Clarence H., Santa Ana, Calif., to HAL-3, FPO San Francisco, Calif. 96601
Stevens, Joseph C., Madison, to Hitchcock Clinic, Hanover, New Hampshire 03755
Stevenson, Donald J., 3409 Lake Mendota Dr., Madison 53705
Stricker, Marvin F., 2229 Middleton Beach Rd., Middleton 53562
Sullivan, John F., 1506 South Oneida, Appleton 54911
Taugher, Philip J., 5613 Berry Ct., Greendale, 53129
Wiesen, Richard L., Augusta, Ga., to 21600 Gill Court, Waukesha 53186
Winston, Margaret C., 1029 Spaight St., Madison 53703
Zabors, Thomas E., Milwaukee, to 316 East Silver Spring Drive, Whitefish Bay 53217
Zahl, W. H., P. O. Box 84, South Milwaukee 53172
Zimmermann, Timm A., Westby, to 4204 89th Ave., S. E., Mercer Island, Wash. 98040

REMOVED FROM MEMBERSHIP

Adams, Robert W., Barron–Washburn–Sawyer–Burnett County
Bessire, Milton C., Dane County, resigned
Chunn, Albert G., Dane County, resigned
Foerster, Harry R., Milwaukee County
Groessl, Peter J., Brown County, resigned
Rikkers, Donald F., Milwaukee County, resigned
Schneider, J. Morton, Dane County, resigned
Scott, John C., Milwaukee County, transferred to Washington
Sharpe, Harve Roy, Fond du Lac County
Vakili, Hossein, Price–Taylor County, transferred to Washington
Wahl, Joseph W., La Crosse County

DEATHS

Bingol, Orhan G., Walworth County, Apr. 26, 1968
Potts, Willis J., non-member, May 5, 1968
Edmondson, C. C., Waukesha County, May 9, 1968
Dernbach, George P., Waupaca County, May 22, 1968
Holbrook, Arthur T., Milwaukee County, May 22, 1968
Neupert, Carl N., Dane County, May 22, 1968
Wilkinson, John J., Milwaukee County, May 28, 1968
Connell, F. Gregory, Winnebago County, May 29, 1968
Stebbins, George G., Dane County, June 2, 1968
Biller, Saul Earl, Milwaukee County, June 8, 1968
Murphy, Francis D., Milwaukee County, June 15, 1968
Baker, Rowe G., Lincoln County, June 19, 1968
Bemis, Ira M., Sheboygan County, June 21, 1968
Hagerty, Warren T., Brown County, July 1, 1968
Dean, James Philip, Dane County, July 21, 1968

* * *

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the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 67, No. 10 OCTOBER 1968

SCIENTIFIC ARTICLES

Significant Clinical Manifestations of Molar Pregnancy, by Frederick J. Hofmeister, M.D. and William O'Leary, M.D., Milwaukee ---- 509

Culdoscopy at University Hospitals: 1964–1967; review of 100 consecutive cases, by Gloria E. Sarto, M.D., Margaret Crumpacker, M.D., William Kiekhofer, M.D., and Alwin E. Schultz, M.D., Madison ---- 514

The Many Facets of Dermatomyositis, by Arthur C. Curtis, M.D., F.A.C.P., Ann Arbor, Michigan ---- 519

Cervical Pregnancy; case report, by E. Y. Strawn, M.D., Milwaukee ---- 522

Therapeutic Dilemmas: Status Asthmaticus (No. 12 of a Series), by Harry Beckman, M.D., Milwaukee ---- 524

Comments on Treatment: Treatment of Acute Leukemia in Children, by L. Gilbert Thatcher, M.D., Milwaukee ---- 530

SPECIAL FEATURES

Official Call for Scientific Exhibits: 1969 Annual Meeting ---- 13

Annual Photography Contest: 1969 Annual Meeting ---- 15

Limb Prognosis in Lumbar Sympathectomy (abstract) ---- 521

Suture Reinforcement of the Incompetent Cervix (abstract) ---- 533

Sporotrichosis, by H. Grant Skinner, M.D., Madison ---- 534

Oxytocics: Employment and Safeguards (obstetrical brief), by John R. Evrard, M.D., Milwaukee ---- 534

Refresher Courses for Inactive Nurses, by Signe S. Cooper, R.N., Madison ---- 61

Wisconsin's Health: County Health Committees Face Challenge, by E. H. Jorris, M.D., State Health Officer ---- 62

EDITORIALS

President's Page: Leaves of Change, by William D. James, M.D., Oconomowoc ---- 535

The Ductus Issue ---- 536

Educational Opportunity ---- 537

REGULAR FEATURES

Publication Information ---- 6

Medical Meetings ---- 7

Letters ---- 538

Medical Green Sheet ---- 539

Medical Student Forum ---- 63

State Medical Society ---- 65

Physician News ---- 67

County Societies ---- 73

Specialty Societies ---- 74

Section on Ophthalmology ---- 75

Paramedical/Ancillary ---- 79

Obituaries ---- 81

Society Records ---- 84

Bookshelf ---- 87

Physicians Exchange ---- 90

Index to Advertisers ---- 92

Wisconsin Physicians Service ---- 93

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Journal
Established 1903

Annual Subscription ---- $10.00
Single Copy ---- 1.50
Previous Years' ---- 3.00
January Blue Book ---- 5.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago, Illinois 60610; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin 54481.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.

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Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual.* Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 WISCONSIN

Nov. 16: Fall annual meeting of Wisconsin Society of Pathologists, Marquette School of Medicine, Milwaukee.

1968 NEIGHBORING STATES

Oct. 28–30: Clinical Reviews, Mayo Clinic and Mayo Foundation, Rochester, Minn.

Oct. 28–Nov. 1: "Renal Disease," American College of Physicians, University of Illinois School of Medicine, Chicago, Ill.

Nov. 11–13: Clinical Reviews, Mayo Clinic and Mayo Foundation, Rochester, Minn.

1968 OTHERS

Nov. 7–9: Second Annual Postgraduate Conference on "Today's Hospital Problems: An Interdisciplinary Approach," Mound Park Hospital Foundation with joint sponsorship of the University of Florida's J. Hillis Miller Health Center, The Tides Hotel and Bath Club, Redington Beach, Fla.

Nov. 11–14: Interstate Postgraduate Medical Association Assembly, Pittsburgh, Pa.

Nov. 11–15: "Cancer and Internal Medicine," American College of Physicians, Memorial Hospital for Cancer and Allied Diseases, New York, N.Y.

Nov. 13–16: Forty-seventh annual convention, National Easter Seal Society for Crippled Children and Adults, Sheraton-Boston Hotel, Boston, Mass.

Nov. 19–20: 22nd Annual Meeting, American Heart Association Council on Arteriosclerosis, Bal Harbour, Fla.

Nov. 20–22: Sixtieth annual conference, National Society for the Prevention of Blindness, Roosevelt Hotel, New York City.

Nov. 21–24: 41st Scientific Sessions, American Heart Association, Bal Harbour, Fla.

Nov. 22–23: Psychedelic Drugs meeting, The Hahnemann Medical College and Hospital of Philadelphia, Pa.

Nov. 25–26: Annual Assembly Meeting, American Heart Association, Bal Harbour, Fla.

Nov. 25–26: Meeting, American Society of Nephrology, Shoreham Hotel, Washington, D.C.

Dec. 2–6: "Physical Methodology in Medical Research," American College of Physicians, Massachusetts Institute of Technology, Cambridge, Mass.

Dec. 10–13: "Cardiology—1968," Institute for Cardiopulmonary Diseases of Scripps Clinic and Research Foundation, American College of Cardiology, La Jolla, Calif.

Dec. 13–15: "Advances in Coronary Artery Disease," American College of Cardiology, Waldorf–Astoria Hotel, New York, N.Y.

1968 AMA

Dec. 1: Tenth National Conference on the Medical Aspects of Sports, AMA, Hotel Deauville, Miami Beach, Fla.

Dec. 1–4: Clinical Convention, AMA, Miami Beach, Fla.

1969 NEIGHBORING STATES

April 20–25: 50th Annual Session, American College of Physicians, Conrad Hilton Hotel, Chicago, Ill.

Apr. 30–May 4: M.A.C. VI-Midwest Anesthesiology Conference, Illinois Society of Anesthesiologists, Palmer House, Chicago.

1969 OTHERS

Jan.: AHA Council on Clinical Cardiology—"Cardiopulmonary Physiology," San Francisco, Calif.

Jan. 12–17: Annual meeting, Society for Cryosurgery, Hilton Piaza, Miami Beach, Fla.

Feb. 3–5: Sectional meeting, American College of Surgeons, featuring general surgery, urology, orthopedics, Fontanelle Hotel, Omaha, Neb.

Feb. 8–13: Annual Congress and Teaching Seminar, International Academy of Proctology, Hollywood Beach Hotel and Country Club, Hollywood, Fla.

Feb. 24–26: Sectional meeting, American College of Surgeons, featuring gynecology-obstetrics, neurosurgery, general surgery, and symposium on trauma, Brown Hotel, Louisville, Ky.

Mar. 10–12: Joint meeting for doctors and nurses, American College of Surgeons, featuring general surgery and eight surgical specialties, Sheraton–Boston Hotel, Boston, Mass.

Mar. 28–30: International Congress (Giornate Mediche Internazionali) featuring molecular pathology, endoscopy, blood circulation and respiratory apparatus, and psycho-pharmaceutics, Istituti Ospitalieri of Verona (Italy).

Apr.: AHA Council on Clinical Cardiology—"Clinical Electrocardiography and Vectorcardiography," Augusta Ga.

Apr. 18: Annual symposium on Infectious Diseases, American Academy of General Practice, Battenfield Auditorium, Kansas City, Kan.

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

June: AHA Council on Clinical Cardiology, title and location to be announced.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Winter: AHA Council on Clinical Cardiology—"Clinical Use of Cardiovascular Drugs," La Jolla, Calif.

1969 AMA

July 13–18: Annual meeting, American Medical Association, New York City.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

1970 OTHERS

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

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MEDICAL MEETINGS *continued*

UW and SMS In-Depth Programs

The newest series of one-day, in-depth teaching programs for 1968–1969 season has been arranged by the University of Wisconsin and the State Medical Society of Wisconsin in cooperation with the Madison Chapter of the Wisconsin Academy of General Practice and Merck Sharp & Dohme Postgraduate Program. As in previous programs the meetings consist of morning sessions at the University Hospitals and afternoon sessions, including lunch, at the State Medical Society headquarters in Madison. A change in the format of the afternoon session splits registrants into small groups for one hour to enable them to discuss their problems with one or two of the faculty, thus affording an opportunity for individual case or problem discussion.

Registration fee is $5.00 per program, or $20.00 for all four, tax deductible, as the programs are presented through the Charitable, Educational and Scientific Foundation of the State Medical Society. Registration fee includes lunch. Five hours of AAGP credit will be allowed. The complete program and schedule appears on the opposite page.

International Wine–Health Symposium

An International Symposium on Wine and Health will be held Saturday, Nov. 9, at The University of Chicago Center for Continuing Education, 1307 E. 60th St., Chicago.

Program chairman is Dr. Salvatore P. Lucia, University of California School of Medicine, San Francisco.

Cardiopulmonary Resuscitation Training Course

A one-day course in Cardiopulmonary Resuscitation Training is being offered at the University of Pittsburgh Medical School on three different dates. The course has been offered for Oct. 9, and will be repeated on Dec. 11 and Apr. 9.

Registration deadline for the Dec. 11 session is Nov. 27. Registration information is available from Wisconsin Heart Association, 205 West Highland Avenue, Milwaukee 53203.

The one-day course consists of lectures, demonstrations, mannequin practice, laboratory experience including drug administration, treatment of ventricular fibrillation and arrhythmias in addition to external compression and ventilation, review of training materials and methods, and techniques of organizing community programs.

AMA Rural Health Conference

The 22nd National Conference on Rural Health will be held at the Philadelphia Marriott Motor Hotel in Philadelphia, Pa., March 21–22, 1969. The conference is sponsored by the AMA's Council on Rural Health.

meetings continued on page 10

UNIVERSITY OF WISCONSIN AND STATE MEDICAL SOCIETY

IN-DEPTH PROGRAMS

in cooperation with the Madison Chapter of the American Academy of General Practice, the Charitable, Educational and Scientific Foundation of the State Medical Society, and the Merck Sharp & Dohme Postgraduate Program

A continuation of one-day IN-DEPTH teaching programs starting at 10 a.m. at University Hospitals for patient discussions, in Room 300 (third floor); with lunch at 12:30 p.m. at the State Medical Society headquarters (330 East Lakeside), followed by afternoon program from 1:15 to 4:00 p.m. NEW THIS YEAR: Registrants will be split into small groups from 3 to 4 p.m. on each of the days for discussion of problems with one or two of the faculty. REGISTRATION FEE: $5.00 per meeting, $20.00 for all four! CREDIT: Five hours by AAGP.

Wed. Dec. 4 1968	**CORONARY CARE UNITS—TWO YEARS LATER** FACULTY: Richard H. Wasserburger, MD; Anthony J. Richtsmeier, MD; William Rock, MD; John J. Brandabur, Jr., MD; John H. Morledge, MD; Neville Bittar, MD; and John H. Wishart, MD TOPICS: Patient Presentations Showing Different Problems of Myocardial Infarction . . . Follow-up Experiences of Four Coronary Care Units . . . Wisconsin Regional Medical Program Contributions . . . Pacers . . . New Drugs
Thurs. Jan. 16 1969	**"I'M TOO TIRED, DEAR"** FACULTY: Andrew S. Ferber, MD, Director of Family Studies, Albert Einstein College of Medicine, New York; Carl A. Whitacker, MD, assisted by the Resident Staff, Department of Psychiatry, University of Wisconsin TOPICS: It is planned to use the Psychodrama as a method of Problem Presentation and Resolution of Stress . . . Inter-personal Relationships in Marriage . . . Guidelines for Assisting Couples to Improve Their Relationships to Each Other
Wed. Feb. 19 1969	**RESPIRATORY THERAPY** FACULTY: Paul O. Simenstad, MD; George E. Webb, Jr., MD; Claude A. Taylor, MD; Mrs. Dorte Frandsen, Special Assistant in Chest Physiotherapy; Mr. Dennis F. Garrett, ARIT; Mr. John Uselmann, ARIT TOPICS: Patient Presentations . . . Chronic Lung Disease with Emphasis on Emphysema . . . Use of Ventilators and Other Adjuncts in the Treatment of Pre- and Postoperative Surgical Patients . . . Demonstration of Chest Physiotherapy
Thurs. Mar. 20 1969	**FEMALE HORMONES AT AGE FIFTY** FACULTY: F. Stoddard Jackson, MD; C. Weir Horswill, MD; Luis B. Curet, MD; William Kiekhofer, MD; and Gloria E. Sarto, MD TOPICS: Case Presentations . . . Indications . . . Selection of Patients . . . Management . . . Management of Complications

Frontiers of Medicine: 1968–1969

On the second Wednesday of each month, from October through May, 1968–1969, the medical staff of The University of Chicago will present its fourth series of conferences on recent advances in medicine, designed for physicians in practice. The program will include a wide range of subjects, as indicated by the program schedule below.

These conferences given by members of the Departments of Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Psychiatry, Radiology, and Surgery provide physicians with a comprehensive review of recent developments, with particular emphasis upon clinical application. Physicians are invited to register for the entire series of eight conferences, or for individual programs. Early registration is recommended.

OCT. 9: *Drugs of Abuse;* NOV. 13: *Current Concepts in Pediatric Surgery;* DEC. 11: *Malabsorption Problems;* JAN. 8: *Thyroid Disease;* FEB. 12: *Diagnosis and Management of Respiratory Insufficiency;* MAR. 12: *The Acute Abdomen;* APR. 9: *Pathogenesis, Diagnosis, and Treatment of Rheumatoid Arthritis;* and MAY 14: *Management of the Patient with Acute Myocardial Infarction.* This program is acceptable for 25 prescribed hours by the American Academy of General Practice.

Fee for the series of eight programs: $75.00. Fee for individual sessions: $15.00. Additional information: Frontiers of Medicine, The University of Chicago, 950 East 59th Street, Chicago, Ill. 60637; tel. MUseum 4–6100, ext. 5272.

AMA Clinical Convention Dec. 1–4

A showcase of scientific achievements and studies will be seen in Miami Beach, Fla., Dec. 1–4, when the American Medical Association holds its 22nd Clinical Convention.

A total of 125 scientific exhibits, covering a variety of medical disciplines, will be set up at the convention center. The displays will be available for viewing from noon Sunday until the session ends Wednesday afternoon.

Live color telecasts dealing with medical problems will be shown on Monday, Tuesday and Wednesday to complement the general session by providing additional educational information. The television programs will cover obstetrics-gynecology, cerebral vascular disease and amputee and stroke rehabilitation.

Also, about 30 medical motion pictures will be shown as part of the scientific program at the 22nd Clinical Convention.

At least five premiere showings are planned. Among these are "Shock and Recognition and Management" and "Granulomatous and Ulcerative Colitis: Diagnosis and Differential Diagnosis."

A film symposium, with panel discussion, is planned on "Problems of Chest Pain." A question-and-answer session will be included.

The Scientific Program for the 1968 Clinical Convention will be published in the October 21 issue of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Continuing education will get big emphasis at the Clinical Convention. On Dec. 2–4 postgraduate courses will be offered on diabetes, fluid and electrolyte balance, and thyroid disease. Two one-hour sessions will be held daily.

And four breakfast roundtables, which have proved to be highly successful at past sessions to discuss many facets of medicine, are scheduled. In addition, there will be clinical workshops on eye problems, cardiovascular disease, diabetes, and office urology.

Dearholt Lectures

Dr. Marvin Kuschner, director of pathology at Bellevue Hospital in New York, has accepted an invitation to deliver the 1968 Dearholt lectures.

He will speak at the University of Wisconsin in Madison on Nov. 12 and at Milwaukee County General Hospital in Milwaukee on Nov. 13.

Doctor Kuschner received his medical degree from the New York University School of Medicine; and he interned at Kings County Hospital in Brooklyn. He has served as an associate professor of pathology at Columbia University and is now professor of pathology at New York University.

Dearholt lectures are presented annually to give practicing physicians and students at Wisconsin's medical schools an opportunity to see and hear outstanding leaders of the medical profession. They are sponsored by Marquette Medical School, the University of Wisconsin, the Wisconsin Anti-Tuberculosis Association, and the Wisconsin Thoracic Society.

International Congress, Italy

The *Giornate Mediche Internazionali* will present a Congress for leaders in the fields of Medicine Mar. 28–30, 1969, at the Istituti Ospitalieri of Verona (Italy).

Subjects to be covered include: (1) Some Aspects of Molecular Pathology, (2) New Gains in Endoscopy, (3) The Circulation of the Blood and Respiratory Apparatus: New Concepts and New Means of Research in These Subjects, (4) Possibilities of Developing and Limits in the Employment of Psychopharmaceutics, and (5) The Doctor in and Throughout the Coming Years.

Contact: Secretariat, *GMI*, Istituti Ospitalieri di Verona, via Bassini, n. 6, Borgo Trento, Verona (Italy).

Pan-Pacific Surgical Association

The Eleventh Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, Oct. 14–22, 1969, following the meeting of the American College of Surgeons in San Francisco, Oct. 6–10.

The scientific program will consist of some 350 speakers in all surgical specialties. Concurrent meetings will be held in Colon and Anorectal Surgery, General Surgery, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Thoracic-Cardiovascular Surgery and Urology. Included in the program will be meetings in Anesthesiology and Radiology.

International Academy of Proctology, Seminar

The 21st Annual Congress and Teaching Seminar of the International Academy of Proctology will be held Feb. 8–13, 1969, at the Hollywood Beach Hotel and Country Club, Hollywood, Florida.

Academy business sessions will take place on Sunday, Feb. 9, and the important and informative scientific sessions will take place each morning, Monday, Feb. 10, through Thursday, Feb. 13. Afternoons will be free to enjoy the many inviting guest facilities and entertainment programs offered by the hotel.

A cordial invitation is extended to the proctologist and gastroenterologist to participate in the scientific sessions of the meeting by presentation of a paper. Doctors from various parts of the world will be taking part in this part of the program, and the sessions are open to all physicians who desire to attend.

Since the Academy has selected a height-of-season time for this meeting, all arrangements must be complete well in advance, and the deadline date is DEC. 15 for all registrations. Contact the Executive Office, 147–41 Sanford Avenue, Flushing, N. Y. 11355.

American College of Surgeons Meetings

The American College of Surgeons has scheduled three sectional meetings in 1969: Feb. 3–5, Omaha, Neb.; Feb. 24–26, Louisville, Ky.; and Mar. 10–12, Boston, Mass., the annual combined meeting for doctors and nurses.

Surgeons of outstanding ability will act as teachers for the programs which are short, concentrated sessions that are designed to inform the medical profession at large about developments in surgery. Attention will be focused on newest ways of handling everyday problems through panels, symposia, "How-I-Do-It" clinics, scientific papers, and selected films. Each meeting features sessions in general surgery plus two or more surgical specialties.

The Omaha meeting on Feb. 3–5 will be held at the Sheraton–Fontanelle Hotel and will feature in addition to general surgery, specialty sessions in urology and in orthopedics including trauma.

The Brown Hotel in Louisville is the setting for the Feb. 24–26 meeting which will feature the specialties of gynecology-obstetrics and neurosurgery in addition to daily sessions in general surgery. A symposium on trauma will open the meeting, featuring developments in transportation and management of the injured, and various acute injuries.

A joint meeting for doctors and nurses will be Mar. 10–12 in Boston, Mass. The Sheraton–Boston will be headquarters for doctors and the Statler–Hilton for nurses. There is no registration fee for nurses.

In addition to general surgery, there will be programs in eight surgical specialties: proctology, orthopedics and trauma, thoracic and cardiovascular surgery, gynecology-obstetrics, otorhinolaryngology, ophthalmic surgery, urology, and plastic surgery.

The nurses concurrent sessions will include discussions of future education for nurses, nursing law, bacteriological housekeeping in the operating room, current reports on burn care—including anesthesia, hypnosis and surgical management, materials, procurement and supply distribution, disposables versus reusables, advanced surgical procedures on the heart, liver, kidney, adrenals and pancreas, surgical technique of portacaval shunt, and thoracic surgery in children.

Official housing forms for all meetings are available from: Mr. T. E. McGinnis, Manager of Exhibits and Meeting Arrangements, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611.

Postgraduate Programs, California

The Division of Maternal and Child Health of the University of California School of Public Health at Berkeley announces the following postgraduate programs for pediatricians, obstetricians, and other physicians interested in receiving training in the field of Maternal and Child Health. These programs all lead to the degree of Master of Public Health. Tax-exempt fellowship support is available.

Maternal and Child Health. A 9-month program in planning, organizing, and operating comprehensive health services for mothers and children.

Family Planning. A 9-month academic program providing intensive work in family planning as part of the general graduate preparation of maternal and child health specialists.

School Health. A 9-month academic program providing intensive work in school health as part of the general graduate preparation of maternal and child health specialists.

The Multiply Handicapped and Mentally Retarded Child. A 21-month academic and clinical program in planning, organizing and operating community services for children with multiple handicaps, including mental retardation. This program is primarily for Board-certified or Board-eligible pediatricians, or for physicians on the staff of institutions for the mentally retarded or handicapped children.

Career Development Programs. Three-year academic and residency programs consisting of one year of academic training leading to the degree of Master of Public Health combined with residency training in Pediatrics or Obstetrics–Gynecology. The training emphasizes planning, organization and operation of comprehensive health programs.

Applications are now being accepted for the group entering in July or September, *1969*. For information, write to Helen M. Wallace, MD, School of Public Health, University of California, Berkeley, Calif. 94720.

Society for Cryosurgery

The Society for Cryosurgery will hold its annual meeting at the Hilton Plaza, in Miami Beach, Fla., Jan. 12–17, 1969.

Professor B. Luyet of the University of Wisconsin Medical Center, Madison, will participate in the program on the subject of Cryobiology.

All physicians and surgeons who wish to keep informed of the rapid advances being made in cryogenic procedures for the treatment of diseases are invited to attend the meeting.

Contact: John G. Bellows, MD, PhD, Secretary, 30 N. Michigan Ave., Chicago, Ill. 60602.

Florida Meeting on Hospital Problems

The Mound Park Hospital Foundation with the joint sponsorship of the University of Florida's J. Hillis Miller Health Center will present a second annual postgraduate conference on "Today's Hospital Problems: An Interdisciplinary Approach" on Nov. 7–9.

This postgraduate conference will be completely comprehensive and designed specifically for physicians who hold hospital staff leadership positions, hospital administrators, hospital trustees, and such allied personnel selected by hospital administration and division chiefs.

This program is acceptable for 18 accredited hours by the American Academy of General Practice for those who desire such credit. The teaching faculty will be composed of selected guest lecturers and an expert staff from the University of Florida and the Foundation.

Contact: Mound Park Hospital Foundation, Inc., St. Petersburg, Fla. 33701.

SERVICES TO PHYSICIANS AND THE PUBLIC

from the

PUBLIC INFORMATION DEPARTMENT OF THE STATE MEDICAL SOCIETY

The following services are provided to member physicians and the general public, under the direction of the Commission on Health Education—a standing committee of the Council. For the most part they are designed to assist the physician in preparing for participation in health education events such as speeches to non-medical audiences, or to provide factual health information directly to the general public. Address requests, or have your patients write: Public Information Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LOAN PACKETS

Packets of reference materials are provided, on a loan basis, on such topics as Fluoridation, Establishing a Practice, Health Fads and Fallacies, Alcoholism, Health Careers, Emotional Aspects of Malignancy, and numerous others.

FILM SERVICE

An index of films, suitable for both medical and non-medical audiences, is maintained by the Society. Please be as specific as possible concerning the desired topic. Since the Society does not maintain a film library and all films must be ordered from another source, two weeks notice is desirable. Cost normally involves only return postage, however in some cases there is a rental or service charge to be paid by the recipient.

HEALTH CAREERS MATERIALS

Materials on careers in medicine are available as references for physicians participating in Career Days and leaflets are available in quantity for distribution to groups. Reference materials on careers ancillary to medicine, and sources of loans and scholarships are also available.

HEALTH EDUCATION LITERATURE

Single pamphlets are available on a wide range of topics for individuals seeking factual information on health.

MOUTH-TO-MOUTH BREATHING AND CLOSED CHEST CARDIAC MASSAGE

Films and a demonstration manikin are available for special programs on mouth-to-mouth breathing and closed chest cardiac massage. The latter topic is considered appropriate for physicians, nurses, policemen, firemen and rescue personnel, and requires supervision of a physician trained in the technique.

SPEAKERS SERVICE

While it is normally desirable to have a local physician fulfill speaking engagements in his community, speakers are available on the state level where a special topic or audience size makes it desirable.

Refresher Courses for Inactive Nurses

By SIGNE S. COOPER, R.N., Madison, Wisconsin

TODAY 20 PER CENT of the budgeted positions in nursing are unfilled. The Surgeon General's office estimates that 80,000 more nurses will be needed by 1970. These figures suggest that present critical shortages of prepared nurses may become even more serious. They also reflect a marked increase in employment opportunities for nurses, since the number of practicing nurses per 100,000 population has been constantly increasing since the turn of the century.

Many efforts have been directed toward meeting these rapidly expanding needs for nurse practitioners. Nurses not currently employed in nursing are one resource that may ease this critical need. These nurses spend several years training for a professional career in nursing, actively work in their profession for only a few years, and then "retire" to marry and raise a family.

It is sometimes stated that approximately the same number of nurses are inactive as those currently employed. However, this is not an accurate figure of potential returnees, since this number includes those who are too old or ill to seek employment, or whose family responsibilities prohibit a return to practice. Nevertheless, inactive nurses comprise a pool of potential employees. Bringing their knowledge and skills up-to-date will help facilitate their return to employment.

Wisconsin is one of the 46 states participating in a nationwide program designed to promote the return of the inactive nurse to practice. In June 1967, federal funds were made available for the employment of a nurse coordinator for each state for a project designed to activate health personnel. In Wisconsin, this contract was awarded to the Department of Nursing, University Extension, the University of Wisconsin. In addition, federal funds became available under the Manpower Development and Training Act to permit nurses to enroll in free refresher courses.

Courses for inactive professional nurses have been offered by University Extension since 1954. Refresher courses have been given in 36 different Wisconsin communities. Over 1,450 nurses have enrolled in these courses, and approximately half of these nurses have returned to practice.

To launch this year's efforts, a survey of the state's inactive nurses was conducted by the Wisconsin State Employment Service in cooperation with the Wisconsin Nurses Association. The study was done in June 1967. Members of the 18 district nurses associations throughout the state assisted in locating inactive nurses and encouraged them to respond to the questionnaires. The data were collected and compiled by the State Employment Service, and were published in a document entitled *Reemployment Factors of Inactive Nurses in Wisconsin.*

This survey revealed that approximately three-fourths of the 1,160 inactive nurses who responded were interested in returning to practice at some time. Home and family responsibility was cited as the most frequent reason for inactivity. The majority of those who planned to return to nursing indicated a need and interest in taking a refresher course.

Inactive nurses are sensitive to the rapid changes in nursing practice which have followed the great technological advances in medicine. This knowledge of change makes them acutely aware of a need for assistance for a return to practice.

Courses for inactive nurses are designed to acquaint them with newer methods and techniques of nursing. A review of former skills can help reassure the nurse that she has retained much more than she suspected. Courses consist of formal classes and supervised hospital practice. Participants are acquainted with all the various sources of information now available to them.

Since the project was initiated, eleven refresher courses have been offered in Wisconsin. Five of these were funded under the Manpower Development and Training Act, so the nurse was not required to pay the usual fee for Extension nursing programs. Six additional courses were funded for September and October.

The rate of return on these courses has been unusually high. In Superior, 10 out of 11 of the nurses who completed the course are employed. In Madison, all 21 enrollees who finished a course in February are working. Nurses who completed courses ending in June anticipated employment in September.

THE EMPLOYING AGENCY

Completing the refresher course is only the first step in assisting the inactive nurse to return to practice. No matter where she is later employed, she needs a good orientation to the institution before she can function effectively on the job.

An inadequate orientation to the job may discourage the returning nurse so that she may quit soon after she has attempted employment. Expecting too much of her too soon may have the same effect. The returning nurse expects to have adequate supervision in her initial employment, and if she is placed in a situation, such as night duty, where she must work alone, she may decide that nursing is not for her. Conversely, the nurse who receives adequate help, who has her questions answered, and who gets the information she needs, may find returning to work a satisfying and rewarding experience.

If the nurse has no major economic need for working, certain factors in the employment setting may influence her decision to return to nursing, or to remain active after she has returned. These factors, identified in the statewide survey, are: inflexible working hours, poor pay, too heavy a work load, and unsatisfactory working conditions. Inability to secure satisfactory household help or to make adequate arrangements for child care while the mother is working also influences this decision.

ROLE OF THE PHYSICIAN

Physicians as well as practicing nurses have a responsibility to provide assistance and encouragement to the returning nurse. An accepting climate may make the difference in retaining a nurse who has completed a refresher course. The medical staff members contribute to this acceptance, perhaps more than they think.

It is unrealistic to expect the nurse who has not practiced for 20 years to function with the same skill and efficiency as those who have been working for some time. More tolerance and less criticism early in the nurse's return to employment may influence her remaining on the job, and may possibly contribute to a more rapid adjustment to employment.

The nurse who has not been practicing, but has raised a family and had a variety of life experiences often has gained maturity that is needed in nursing today. She may have special skills in supporting patients and their families as they live through the crises so often associated with illness. The alert physician will recognize this special attribute of the returning nurse.

Physicians can contribute to the inactive nurse project in another way. In a number of areas they have been invited to teach selected content in the refresher courses, and they have willingly participated.

FUTURE DEVELOPMENTS

The nurse who left the field 20 years ago usually did not intend to return to practice. Consequently, she made no attempt to keep up with her profession. For these nurses, a refresher course becomes a necessity.

With the shortage of nurses today, community pressures are being placed upon inactive nurses to return to practice. To some extent, the nurse may be a reluctant returnee, and may not need to work for financial reasons. Therefore, much encouragement may be required to convince her to return and to stay in practice.

In contrast, the graduate of today is more likely to expect to combine marriage and a career, since this now is more socially acceptable. She will seek ways of keeping up during periods of inactivity, so that she can transfer from housewife to nurse more readily.

The manpower shortages in nursing will not be solved by activating nurses not now practicing. However, it is one approach that provides promise of easing the present critical situation.

REFERENCES

1. AMA Committee on Nursing: 285,000 inactive nurses could turn the tide, *JAMA* 200:779–780 (May 29) 1967.
2. Wisconsin State Employment Service, with Wisconsin Nurses Association: Reemployment factors of inactive nurses in Wisconsin, 1968.

WISCONSIN'S HEALTH by E. H. JORRIS, M.D., State Health Officer

COUNTY HEALTH COMMITTEES FACE CHALLENGE

For the last 55 years Wisconsin has had a law permitting counties to employ public health nurses. Last year the legislature amended this law by broadening the functions and responsibilities of the county health committees and changing the composition of their membership.

The committees are now to be composed of five or more members appointed by the chairman, at least three of which shall be members of the county board. A representative of the State Division of Health appointed by the health officer also serves as a member of the county health committee.

The committees can now employ sanitarians in addition to public health nurses. These changes in the law will help counties to meet their growing health needs.

Environmental health is increasingly more important. With a sanitarian, counties will be able to control environmental health hazards more effectively. The sanitarian can serve in the abatement of nuisances which are a constant concern of the public and of elected officials. A sanitarian is of great help in the development and maintenance of a safe water supply, proper disposal of sewage, liquid and solid wastes, and the control of air pollution.

Public health nurses in the counties are called to serve as information sources, in some cases to an extent which severely limits the time available for nursing services. The amendments permit counties to obtain help in order to provide more nursing services to people.

County health committees now have a challenge and an opportunity to meet public health needs with a professionally-trained staff, each working in a specific area and all working together to meet the needs of the community with consultation from the State Division of Health.

THE MEDICAL STUDENT FORUM

Devoted to the expressions of the medical students at the University of Wisconsin and Marquette medical schools through association with the Student American Medical Association. A feature originated by the State Medical Society of Wisconsin to stimulate closer relationships with the physicians of tomorrow. This space is offered monthly to both schools on an alternating basis, with copy deadline the first of the month preceding the month of publication. Statements and opinions contained herein are those of the students.

OCTOBER 1968

The article below I originally wrote last April for the *Marquette Med-News,* our local student newspaper. The thoughts, however, are still pertinent to our times, and while not shared by the most militant anti-war students at Marquette School of Medicine, do express the opinions of many of the SAMA members.

* * *

WAR IS NO DOUBT one of man's oldest plagues. It can sweep a small country or entangle the entire world leaving behind its charred, disarticulated, and dead. Into this environment the physician is dropped with all his specialized training directed towards triaging, repairing, and returning to battle the broken and torn bodies brought before him. With a scalpel as a gun, I.V. bottle for ammunition, and x-rays as his guidance system, the doctor makes his vital contribution towards the military effort. Without his much-needed support neither the military nor war would march forward (backward?).

TO SERVE?

This is, in essence, the stand recently (last spring) presented at Marquette and taken by nearly 500 medical students across the United States. Many of these signers of a pledge, essentially stating, "I refuse to serve," have joined together in a neonatal organization called the Health Professions Resistance Union. Through this action, crippling of the present war and immunization against future war efforts are sought. Designed as a "preventive medicine" measure, wars' suffering is expected to be eliminated from the population.

The physician that refuses to honor his country's draft call, however, has few alternatives open to him. Not many physicians are being admitted to the U. S. Public Health Service and fewer still are being granted conscientious objector status. Jail is, of course, an alternative, but one's future as a licensed doctor then becomes a real question. Another alternative is leaving the country but this also jeopardizes one's future. Signing the pledge also raises a third contraindication to one's future medical practice. The possibility exists that some future internship or residency committee might question one's patriotism.

Perhaps the most important consideration lies in the oath physicians take—that is, to serve humanity and relieve suffering. While war creates physical and mental injury, it is also true that a country like Vietnam has more endogenous human wastage and suffering per square mile than can be found in the most underdeveloped, crowded, and depressed American city. A physician is then faced with two pathways. Should he seek means to serve man at home or should he attempt to practice his art in the combat zone where he can both relieve the suffering soldiers and treat the unending array of diseases among the native population. The need in Vietnam is great, perhaps the greatest a doctor can find in one concentrated area.

AT HOME OR ABROAD?

The decision is then up to the individual physician since his future, his humanitarian goals, and possibly the future of the world lies in his black bag.—JOHN E. INMAN, President, SAMA—Marquette

UW Technician Training Program in Electroencephalography

A TECHNICIAN TRAINING program in electroencephalography was organized a year and a half ago at the University of Wisconsin Medical Center. The primary objective of this project has been to adequately train technicians in electroencephalography in order to meet the demand for community service in this area.

The number of EEG technicians trained in past years had been only one to two per year at this center. There were many patients who were transferred to the University Hospitals from other communities in the state just for an EEG test, which could have been performed locally if laboratory facilities were available. Good community EEG service could only be assured if the EEG technicians were well trained and met national board standards. The University of Wisconsin Medical Center was thought to be an ideal training center for such personnel. Thus, the present well structured program got underway. It has been supported in part by a Neurological and Sensory Disease Service Project Grant from the Public Health Service.

So that others may profit from the University of Wisconsin experience, a report providing details of the program is available upon request to: Jack D. Grabow, M.D., Department of Neurology, University of Wisconsin Medical Center, 1300 University Ave., Madison, Wis. 53706.

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Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF SEPTEMBER 1968

3 Board of Trustees, Dane County Medical Society

4 SMS Commission on State Departments

6 SMS Ad Hoc Committee on Medical Practice Act

8 SMS Division on Nervous and Mental Diseases of Commission on State Departments

9 Legislative Advisory Committee, Wisconsin Association of Professions

9 Stroke Study Committee, Wisconsin Regional Medical Program

9 Advisory Committee on Extended Care Facilities, Dane County Medical Society

11 Planning Committee, Wisconsin Regional Medical Program

12 Coding Committee, Wisconsin Association of Clinic Managers

12 Executive Committee, Commission on Public Policy

12 Board of Directors, Wisconsin Association of Professions

15 SMS Division on Rehabilitation of Commission on State Departments

19 Planning Committee of SMS Council

19 Subcommittee on Scholarships, Executive Committee of CES Foundation

20 Executive Committee of SMS Council with Representatives of Faculty of University of Wisconsin Medical School

23 Insurance Advisory Committee, Dane County Medical Society

24 Dept. of Surgery, University Hospitals

26 Executive Committee of SMS Commission on Medical Care Plans

26 Subcommittee on Bylaws, Executive Committee of CES Foundation (Madison)

28 Wisconsin State Universities Student Health Service Association

29 Special Subcommittee of SMS Division on Maternal and Child Welfare of Commission on State Departments to Study Postgraduate Programs for Nurses in Obstetrical Nursing

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics, with the location in parentheses.

Museum Open House Hits Jackpot with Artifact Donation

A statewide invitation to an "Historic Open House" was issued by the Museum of Medical Progress at Prairie du Chien as part of the celebration of "Wonderful Wisconsin Week"—Sept. 15–22. The open house at the national landmark drew an attendance of 700 of which there were 200 from out of state. It was held on Heritage Day, Sunday, Sept. 15, which was the first in the seven-day salute to the State of Wisconsin.

An unexpected windfall came to the Museum during the Open House in the way of artifact donation by Dr. and Mrs. J. H. Kelley of Hillsboro who were spending the day traveling to historic sites. The donation, a unique pair of "delivery harness"—an instrument used in the past to aid in childbirth—belonged to the late Dr. R. S. MacKechnie of Hillsboro.

The Museum of Medical Progress is owned and operated by the Charitable, Educational and Scientific Foundation, Inc. of the State Medical Society of Wisconsin. The complex includes Stovall Hall of Health and the restored military hospital of Old Fort Crawford, which dated back to 1829 and the times of the Northwest Territory.

The Museum will close for the season on October 31.

A BEFITTING CLIMAX TO the Museum's Open House September 15 was the donation of a unique artifact by Dr. and Mrs. J. H. Kelley of Hillsboro. An instrument for aiding in the delivery of babies, it was used by the late Dr. R. S. MacKechnie when he practiced in Hillsboro from 1908 until his death, at age 74, in 1946. The shoe, strap, and hand grip being held above by Doctor and Mrs. Kelley were given to Norman J. Salt (right), director of the CES Foundation which owns and operates the Museum complex. Mrs. Kelley is a daughter of Doctor MacKechnie. The donation was secured by Marty J. Dyrud, Prairie du Chien, who is president of the Crawford County Historical Society and a member of the Board of Curators of the State Historical Society.

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Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8

PHYSICIAN NEWS

Doctor Hildebrand Receives Honor

Dr. Fredric L. Hildebrand of the Riverside Clinic, Menasha, recently completed his Board examinations in Internal Medicine and has been designated a diplomate of the American Board of Internal Medicine.

Dr. Nishioka Contributing Author

Dr. Hiro Nishioka, Green Bay, is the author of the chapter on neurosurgery in the newly released medical textbook, SYNOPSIS OF SURGERY. The book, authored by various professors of the University of Iowa and published by the C. V. Mosby Company, St. Louis, deals with the principles of surgery for medical students and practitioners.

Dr. Buckley Named University Physician

Dr. Roland A. Buckley, Eau Claire, will assume the position of university physician, heading all the activities and service of the University Health Service, Eau Claire State University, Nov. 1. Doctor Buckley is a graduate of Marquette School of Medicine.

Dr. Mortenson Heads Foundation

Dr. Otto A. Mortenson, Madison, recently was elected chairman of the board of directors of the Madison General Hospital Medical and Surgical Foundation, Inc. *Dr. Thomas A. Leonard* was elected vice-chairman and *Dr. William B. Hobbins* was re-elected secretary–treasurer.

Dr. Holm Named Langlade Coroner

Dr. William A. Holm, Antigo, recently was appointed coroner of Langlade County by Governor Warren P. Knowles. Doctor Holm graduated from the University of Minnesota Medical School in 1966 and is a physician at the Antigo General Clinic. He succeeds the late Harry Givvons whose term expires in January.

Dr. Harkness Named to Peace Corps Post

Dr. John W. Harkness, Milwaukee, recently was named as medical director of the Peace Corps. Doctor Harkness, president of Child Care Centers, Inc., served as medical director of the Peace Corps program in the Philippines from 1962 to 1964, when he returned to private practice in Milwaukee. He was an assistant dean of the Marquette medical school from February 1967 to June 1968. He will be in charge of medical aspects of Peace Corps volunteer selection and of their health overseas and will also help plan Peace Corps health programs, such as malaria and tuberculosis surveys and health education.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Carey Receives Navy Medal

Dr. Larry C. Carey, assistant professor of surgery at Marquette School of Medicine, Milwaukee, recently was awarded the Navy Commendation Medal at ceremonies in Washington, D. C. Doctor Carey was honored for "meritorious service" while serving on the staff of the naval hospital at Danang, Vietnam.

Doctor Carey graduated from Ohio State University Medical School and served his residency at County General Hospital. He joined the Marquette staff in 1964 and was drafted in 1966. He has also received the William S. Middleton Lecturer award, State Medical Society of Wisconsin, 1965, and the John and Mary R. Markle Scholar in Academic Medicine, 1965–70. He was certified by the American Board of Surgery in 1965 and is a Fellow of the American College of Surgeons. Doctor Carey has authored or co-authored more than 35 scientific publications.

Dr. Windeck Opens Office

Dr. James L. Windeck, Chippewa Falls, recently re-opened offices in Chippewa Falls. Doctor Windeck graduated from the University of Illinois College of Medicine in 1957, interned in Chicago and then served three years with the U. S. Army Medical Service in Germany. He recently completed 18 months of postgraduate training in internal medicine at the Mayo Clinic, Rochester, Minn. Doctor Windeck is a past president of the Chippewa County Medical Society and president of the Chippewa County Cancer Society. He is on the staff of St. Joseph's Hospital, Chippewa Falls, and also on both of the medical staffs of Sacred Heart Hospital and Luther Hospital, Eau Claire.

Physicians Appointed to Winnebago Staff

Four physicians recently were appointed to the medical staff at Winnebago State Hospital. They are: Drs. Rudolf Hoyer, *Meredith E. Keller*, Clarence E. Moore, and Arthur Brenner.

Doctor Hoyer, a general practitioner and surgeon in Winona, Minn., graduated from the University of Minnesota Medical School and will be in charge of the male geriatric patients. Doctor Keller graduated from the University of Texas' medical branch, Galveston, Tex., and was formerly a physician at Wisconsin State University—Oshkosh, A and M University and Hester Medical Clinic, and also served with the United States Air Force Medical Corps. He has been assigned to the hospital's alcoholic treatment unit. Doctor Moore, now serving as chief of service of the Children's Consultation Service, graduated from the College of Medicine, Iowa City, Iowa, and served his residency in psychiatry

Christmas Cards

CHRISTMAS DINNER AT THE SURGEONS QUARTERS

"Christmas in the Surgeons Quarters at Fort Winnebago was a festive scene as military custom in the early 19th century permitted officers' families to live on post. The Christmas board included beef or venison, rabbit or wild duck, wild rice, native nuts and fruit pie. Even the traditional tree and gifts were there. Today, near Portage, the Surgeons Quarters stand nearly as they did 150 years ago — now restored and operated by the Wisconsin Society, Daughters of the American Revolution."

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PHYSICIAN NEWS *continued*

at the state psychiatric hospital, Iowa City. Doctor Brenner has been assigned to the hospital's adult psychiatric patients. He was formerly with the Manitoba Rehabilitation Hospital, Winnipeg, Manitoba, Canada. Doctor Brenner had his medical training at the University of Vienna Medical School, Vienna, Austria.

Dr. McKenna Joins Beaumont Clinic

Dr. David H. McKenna, De Pere, recently joined the Beaumont Clinic, Green Bay. He graduated from the St. Louis University Medical School and did advance study under a fellowship at the University of Wisconsin, Madison, where he later was an instructor and assistant professor of medicine in the cardiovascular research department. He interned at St. Louis City Hospital and took his residency at St. Louis Veterans Administration Hospital. He also served in the United States Army Medical Corps.

Dr. Werbel Elected President

Dr. Harold J. Werbel, Delavan, recently was elected president of the executive committee of the Lakeland Hospital medical staff to serve a one-year term. Other officers elected were *Drs. Rocco S. Galgano*, Delavan, new vice-president; *Glenn A. Smiley*, Delavan, secretary and treasurer; and *Henry R. Mol*, Elkhorn, last year's president, was elected to a three-year term on the executive committee.

Dr. Breister Joins Staff

Dr. Karl A. Breister, Green Bay, recently was named to the staff of the Shawano County Guidance Center. Besides serving on the staff of the guidance center, Doctor Breister is engaged as the medical director of Iron–Dickensen Mental Health Clinic, Iron Mountain, Mich.; medical director of Brown County Mental Health Center, Green Bay; consultant to Veterans Administration and consultant to Marinette County Hospital.

Dr. Andringa Joins Dean Clinic

Dr. Conrad L. Andringa, Madison, recently joined the staff of the Dean Clinic. Doctor Andringa graduated from the University of Wisconsin Medical School and served his internship at North Carolina Memorial Hospital. He took his residency in pediatrics at University Hospitals, Madison, and served for two years in the United States Air Force.

Dr. Taugher Opens Office

Dr. Philip J. Taugher, Hales Corners, recently opened his office in the Whitnall Medical Clinic, Hales Corners. Doctor Taugher graduated from the Marquette School of Medicine and served an internship at St. Joseph's Hospital, Marshfield, and an integrated residency program in ophthalmology at Marquette.

Dr. Lobeck to Head Discussion Group

Dr. Charles C. Lobeck, Madison, will be chairman of the roundtable discussion at the 37th annual meeting of the American Academy of Pediatrics to be held in Chicago, Oct. 19–24. Doctor Lobeck will head the group entitled "Fluids and Electrolytes."

Dr. Stripling Joins Clinic

Dr. Burnell D. Stripling, specialist in internal medicine, recently joined the staff of the Marinette Medical Clinic. Doctor Stripling graduated from the New York Medical College and interned and took his residency training at Los Angeles County Hospital and Colorado Springs, Colo. He served in the United States Navy Medical Corps from 1966 to 1968.

Madison Doctor Served with Medico

Dr. Jay M. Levy, University of Wisconsin cardiologist, spent the month of July in Honduras serving as a volunteer specialist for MEDICO, a service of CARE. He assisted a MEDICO team of eleven U.S. and Canadian physicians, nurses, and technologists stationed in Honduras to train their local counterparts and treat patients. He demonstrated the procedures and techniques of his specialty and lectured at Occidente Hospital, Santa Rosa; Honduran Medical College, Tegucigalpa, and Leonardo Martinez Hospital, San Pedro, each of which is aided by the MEDICO team.

Doctor Levy is an assistant professor in the department of pediatrics of the UW Medical Center. Before he came to Wisconsin in 1966, he served as an associate cardiologist at Children's Hospital, Boston, and as an instructor in pediatrics at Albert Einstein College of Medicine, New York City.

About 100 United States specialists a year volunteer for one-month terms at their own expense at MEDICO installations in Algeria, Afghanistan, Dominican Republic, Honduras, Malaysia, and Tunisia. MEDICO was founded in 1958 by the late Dr. Tom Dooley and Dr. Peter Comanduras. It was merged with CARE in 1962 and is coordinated with the latter's overseas Self-Help programs in food production, education, health, vocational training, and community development.

Physicians interested in the program may contact MEDICO, 660 First Avenue, New York, N.Y. 10016; tel. (212) 686–3110.

Waukesha Physician in Vietnam

A young Waukesha physician, Dr. Paul V. Cloninger, in one week's time learned that "war is hell." Three days after his plane touched down in Saigon in August, he was loaned a pair of jungle fatigues and air-assaulted onto a landing strip under fire. He

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HESCOR contains: Hesperidin Purified, 100 mg., and Ascorbic Acid, 100 mg. Dose: for active capillary hemorrhage or threatened abortion, 2 tablets t.i.d.; for prevention of capillary hemorrhage and to maintain normal capillary function, 1 tablet t.i.d. Contraindications: none.

[1] Gale, E. T. and Thewlis, M. W., Geriatrics 8:80, 1953
[2] Personal Communication: R. C. Brunner, Pharmaceutical Div., Sunkist Growers

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was mortared three times and walked into a Communist ambush set up by more than 200 men.

Doctor Cloninger joined the Army after completing his internship at San Joaquin General Hospital at Stockton, Calif., in July. After five weeks of Army medical orientation and one week of military schooling at Fort Sam Houston in San Antonio, Tex., he was shipped directly to Vietnam where there is a critical shortage of physicians.

Dr. Kory Named to Regional Heart Group

Dr. Ross C. Kory, president of the Wisconsin Heart Association and associate chief of staff of research service at the Veterans Administration Center in Wood, was recently named to the newly organized North Central Regional Committee of the American Heart Association.

Dr. Heitzman Honored for 30 Years

Nearly 100 Green Bay physicians were present at St. Mary's Hospital Sept. 12 to honor *Dr. Holly Heitzman* at a testimonial dinner in recognition of his 30 years of service to the hospital and the community. Another 50 persons were on hand to celebrate the occasion.

Dr. Donel Sullivan, chief of staff, reminded the guests that Doctor Heitzman was originally both pathologist and radiologist for St. Mary's and Bellin Memorial Hospital. Several other speakers honored Doctor Heitzman for his "goodness as a Christian gentleman and his excellence as a scientist." They included *Dr. Leonard Miller*, president of the Brown County Medical Society; Walter Redeker, principal of Redeemer Lutheran School; and *Dr. G. M. Shinners*, representing the Wisconsin Department of Health and Social Services.

The physicians of the hospital presented Doctor Heitzman, who is an avid collector of clocks, with a banjo clock and an inscribed plaque.

Attend Comprehensive Medicine Meeting

Two Milwaukee doctors participated in the annual scientific meeting of the International Society for Comprehensive Medicine held Sept. 20–21 in Chicago. Anthony Sances, Jr., Ph. D. Marquette School of Medicine, and *Dr. Edward Krumbiegel*, Department of Public Health, were panelists in a symposium on multiphasic screening.

Dr. Weber Speaks on Drugs

Dr. George Weber, Kenosha psychiatrist, Sept. 9 spoke on the increasing use of marijuana and LSD at the fall opening session of the Kenosha Memorial Hospital Auxiliary.

Eye Witness to Czechoslovakian Invasion

Dr. and Mrs. *Frederick W. Blancke* of Madison were in Czechoslovakia as tourists when the Soviet troops crossed the Czech borders in August. In early

September they participated with other eye witnesses in a program aired over WHA radio and the State Broadcasting Service aimed at "telling the Czechoslovakian story" which the Czech people had urged them to do when they left the country. Doctor Blancke is a clinical instructor at the University of Wisconsin Medical School.

Dr. Rastetter Director Health Services

Dr. Joseph W. Rastetter, Assistant Dean of the Marquette School of Medicine since 1964, has been named Director of Student Health Services at Marquette University.

Doctor Rastetter, Wauwatosa, has been a member of the Marquette School of Medicine faculty since 1939. He attended Marquette as an undergraduate and received his Doctor of Medicine Degree from Northwestern University in 1935. He holds the rank of Associate Professor of Medicine and specializes in internal medicine.

Surgery Digest Abstracts from WMJ

Dr. M. A. Polacek's article on "Emergency Room Principles in Limb Amputation and Replantation," which appeared in the March 1968 issue of the WISCONSIN MEDICAL JOURNAL, was abstracted in the August issue of SURGERY DIGEST. Doctor Polacek's coauthors were Dr. Thomas Pagedas and Dr. Edwin Welsh, all of Milwaukee.

* * *

PHS MEDICAL CARE BOOKLET

A self-instruction publication titled, "Legal Aspects of PHS Medical Care—A Programmed Instruction Course," was announced by the Health Services and Mental Health Administration of the Public Health Service. It is a companion piece for use with a reference booklet by the same title.

The material is intended to show legal obligations and barriers that PHS physicians and other medical-health personnel face when they treat patients in facilities of the Public Health Service.

The programmed instruction format of the new manual is a teaching device that combines explanations and test questions to set the stage for easy learning by busy readers. The author, Eli P. Bernzweig, of the PHS Bureau of Health Services, states that none of the material is intended to give definitive legal advice to solve specific legal problems. Instead, readers are given broad legal considerations involved in the provision of medical care.

Both publications are on sale from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. The programmed instruction manual (PHS Publication No. 1468-A) is 55 cents. The related reference booklet (PHS Publication No. 1468) is 50 cents. Single free copies are available from Public Inquiries Branch, U. S. Public Health Service, Washington, D. C. 20201.

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FORMULA: Each teaspoonful (5ml.) elixir or each chew-tab contains:
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REFERENCES:
1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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CHIPPEWA

Discuss Infertility Studies

Members of the Chippewa County Medical Society heard *Dr. Gloria E. Sarto* discuss "Infertility Studies" at the September 3 meeting in Chippewa Falls. Doctor Sarto is a gynecologist at University Hospitals, Madison.

DANE

Over 60 Play in Golf Tournament

Sixty-three members of the Dane County Medical Society participated in the annual golf tournament Sept. 11 at Nakoma Country Club in Madison. Another 20 came for the evening dinner. *Dr. David U. Cookson* had low gross of 73 while *Dr. Frederick J. Davis* had low net of 76.

New members of the Society are: *Dr. Thomas L. Carter*, directr of radiology at Madison General Hospital; *Dr. Joseph M. Connally, Jr.*, resident in plastic surgery at University Hospitals; *Dr. Margaret Crumpacker*, practicing in a hospital-clinic in Hong Kong as a medical missionary; *Dr. Hugh L. Davis, Jr.*, assistant professor of the Division of Clinical Oncology, University of Wisconsin Medical Center; *Dr. Ralph D. Froehlich*, staff psychiatrist at Mendota State Hospital;

Dr. Robert D. Jackson, staff psychiatrist at VA Hospital in Madison; *Dr. Thomas M. McCarthy*, associated with Quisling Clinic; *Dr. Kenneth G. Reeb*, assistant professor, Department of Pediatrics, UW Medical Center; *Dr. H. Grant Skinner*, chief of the Section on Communicable Diseases of the Division of Health, State Department of Health and Social Services; and *Dr. Leonard I. Stein*, psychiatrist at Mendota State Hospital.

* * *

SERVICEMEN HAVE 120 days after discharge to convert their Servicemen's Group Life Insurance through any of the participating private companies.

* * *

BOOKLET: CARDIOVASCULAR SURGERY

A publication entitled "Cardiovascular Surgery" (PHS Publication No. 1701), which describes the most recent advances in the surgical treatment of congenital and acquired heart disease, has been issued by the National Heart Institute of the National Institutes of Health.

As a result of National Heart Institute research support, along with other Federal and voluntary research funds, spectacular strides have been made during recent years in the field of cardiovascular surgery.

Available facilities and services, such as financial assistance, for the prospective surgical patient, also are presented in the fully-illustrated "Cardiovascular Surgery."

Single copies may be obtained, free of charge, from the Heart Information Center, National Heart Institute, National Institutes of Health, Bethesda, Maryland 20014.

Quantity copies may be purchased at 45¢ per copy, $33.50 per 100, from Superintendent of Documents. Government Printing Office, Washington, D.C. 20402.

Physicians whose names appear in italics are members of the State Medical Society.

State Medical Society of Wisconsin

SPEAKERS SERVICE

for

COUNTY MEDICAL SOCIETY MEETINGS

and

COUNTY DISTRICT MEETINGS

County medical societies are urged to use this service which is now in its sixth consecutive year of operation. Speakers from throughout the state as well as those from the two medical schools and the State Division of Health are available through application to the State Medical Society. Applications must be filed at least 30 days before a meeting in order to qualify the speaker for an honorariam and travel expenses. (No speakers are furnished during April and May.)

All areas of scientific medicine are represented, and societies are urged to arrange for at least four scientific programs per year. Other subjects on which speakers are available include legislation, health insurance, interprofessional meetings, school health, mental health, care of the aged, occupational health, medical press relations, maternal mortality, glaucoma detection, cancer and heart, orthopedic and heart clinics.

Request application forms from Edgar S. Gordon, MD, Chairman, Commission on Scientific Medicine, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Sponsored by

COMMISSION ON SCIENTIFIC MEDICINE AND CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION OF THE STATE MEDICAL SOCIETY

in cooperation with

POSTGRADUATE PROGRAM OF MERCK SHARP & DOHME, WISCONSIN DIVISION OF HEALTH, AMERICAN CANCER SOCIETY—WISCONSIN DIVISION, WISCONSIN HEART ASSOCIATION, MARQUETTE SCHOOL OF MEDICINE, AND UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

SPECIALTY SOCIETIES

Wisconsin Urological Society

New officers of the Wisconsin Urological Society for the 1968–1969 season are as follows: president, *Dr. John N. Richards* of Kenosha; president-elect, *Dr. John B. Wear, Jr.*, Madison; and secretary-treasurer, *Dr. John Silbar*, Milwaukee.

Wisconsin Society of Pathologists

The fall meeting of the Wisconsin Society of Pathologists will be held at Marquette School of Medicine, Milwaukee, Nov. 16. There will be morning presentations of scientific papers by members and residents.

An afternoon tissue seminar will be held from 1:30 to 4:30 o'clock on the subject: Pathology of the Cardiovascular System.* Dr. William C. Manion, Chief, Cardiac Pathology Branch, Armed Forces Institute of Pathology, Washington, D. C. will be moderator.

A board of directors meeting will be held at the Holiday Inn Central, followed by the annual dinner and business meeting.

Physicians whose names appear in italics are members of the State Medical Society.

* Seminar slide sets are available on a first-come first-serve basis at $10.00 per set. Kindly address inquiries to the Wisconsin Society of Pathologists, % *Chesley P. Erwin, MD*, Treasurer, 561 North 15th Street, Milwaukee, Wis. 53233.

* * *

WE FLATLY STATE that a person with a physical disability is a much better (insurance) risk than his so-called normal counterpart provided he is properly screened and placed and provided the company has an intelligent safety program. . . . L. A. Hyland, general manager, Hughes Aircraft Company.

SHARE YOUR MEDICAL JOURNALS WITH COLLEAGUES OVERSEAS

Specialty Journals Are Greatly Needed

Through the DOCTOR TO DOCTOR PROGRAM of the American Medical Association, communication between U. S. A. Physicians and overseas colleagues is being achieved in many areas abroad: 22 countries in Asia, 21 in Africa, 12 in Latin America, and 8 elsewhere—a total of 63 countries in which physicians have been introduced through this Program to U. S. A. physicians and are receiving month by month the current medical journals they have requested. These journals are sent directly to the overseas colleague by the U. S. A. physician—their own journals which are forwarded as soon as they have been read.

In this program the individual relationship is stressed—and the journals assigned are those particularly requested by the overseas physician according to special medical interests. This mutual professional interest we hope will lead to further personal correspondence between the two and to a sympathetic understanding of each others problems and aspirations and eventually, we trust—the underlying aim of our Program—to an increase in international goodwill.

Although several thousands of physicians, U. S. A. and overseas colleagues, are now participating in this Program we have hundreds of requests still pending for specialty journals which have not been offered our Program by U. S. A. specialists. Those greatly in demand deal with surgical specialties: Orthopedics, Thoracic and Vascular, E.E.N.T., Neurosurgery, and Roentgenology. Journals on subspecialties in medicine are also needed: Endocrinology, Circulation, Dermatology, Pharmacology, Chest Diseases, etc., as well as Pediatrics, Gynecology and Obstetrics.

To recapitulate: In this Program the U. S. A. physician sends direct to a fellow specialist overseas his specialty journal(s) after they have been read—we supply the name and address of the overseas doctor and the subject of the journal desired. From then on it is a liaison strictly between the two—one in the U. S. A.—and the other "somewhere overseas." Letters we receive indicate this liaison has been not only a very rewarding experience for the individuals involved—but also a significant contribution to international understanding.

If you wish to participate—and we greatly need your cooperation—please send the titles of journals (particularly specialty journals) you will mail to colleagues overseas.

Ada Chree Reid, M.D., Director
AMA DOCTOR TO DOCTOR PROGRAM
10 Columbus Circle—Room 1270
New York, New York 10019

SECTION OPHTHALMOLOGY

OCTOBER 1968 EDITOR: James C. Allen, M.D., Madison

PREPAREO ANO SUPPORTEO BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEOICAL SOCIETY OF WISCONSIN

OPHTHALMOLOGY PATHOLOGY LABORATORY AT THE UNIVERSITY OF WISCONSIN

The Ophthalmology Pathology Laboratory of the University of Wisconsin Medical School has been in operation since 1926 when it was begun by Dr. F. A. Davis. In July 1966, Dr. G. de Venecia returned to this department following a two-year fellowship with Dr. Lorenz E. Zimmerman at the Armed Forces Institute of Pathology, Washington, D. C.

Subsequently, the pathology laboratory facilities have been modernized. Use of paraffin technique has made faster reporting possible to the submitting physician. Previously celloidin technique took a minimum of two to three months whereas at the present time completed reports can be available within a week of receipt of tissue using paraffin.

In cases of sympathetic ophthalmia or tumors, preliminary reports are given within two to three days of receipt of tissue. Representative microslides are included with the final pathological report.

Dr. Mary Pratt joined the Ophthalmic Pathology Department as a Postdoctoral Fellow in December 1967 after two years of private practice at The Monroe Clinic, Monroe, Wis., Department of Ophthalmology. She finished her Ophthalmology residency in 1965 at the University Hospitals in Madison.

The pathology program is an important and integral part of the residency and the fellowship training programs. The Laboratory will welcome any enucleated specimens, orbital and adnexal tissues from Ophthalmologists and Pathologists of this state. Specimens can be sent % Dr. G. deVenecia, Eye Clinic, University Hospitals, Madison, Wis. 53706.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

The Milwaukee Ophthalmological Society has an outstanding program of guest speakers aligned for 1968–69 as follows: Nov. 25, Dr. Robert C. Watzke; Jan. 28, Dr. Harvey Lincoff; Feb. 25, Dr. Richard O. Schultz; Apr. 22, Dr. Walter Gager; and May 15 (annual State Medical Society meeting), Dr. Alston Callahan.

These meetings, held at the University Club of Milwaukee, are preceded by a social period at 5:30 followed by dinner, scientific and business meetings. Guests are welcome and further program information is available upon request to Dr. James V. Bolger, Jr., 102 E. Main St., Waukesha.

ORTHOPTIC CLINIC, MILWAUKEE

The Orthoptic Clinic was established in 1940 by the Milwaukee Ophthalmic Institute and has been in continuous operation since then. It is now one of the three or four oldest orthoptic clinics in the country which has been in continual operation. Currently the clinic is housed in the Milwaukee Curative Workshop at 750 North 18th St., Milwaukee, Wis. 53233. There are one full-time and two part-time orthoptic technicians. The clinic welcomes the referral of patients from ophthalmologists throughout the state for diagnostic or therapeutic orthoptics. The clinic works in close cooperation with the Eye Department at Milwaukee Children's Hospital where there is available a full-time ophthalmological staff consisting of an ophthalmologist-in-chief and two residents.

NEW NEURO-OPHTHALMOLOGIST AT MARQUETTE

Dr. Walter Gager has been appointed assistant professor at Marquette School of Medicine, Department of Ophthalmology. Doctor Gager completed his residency at Marquette and for the past year has been at the University of Miami working with Dr. J. Lawton Smith in neuroophthalmology.

STOUGHTON GETS EYE BANK

The Stoughton Lions Club was recently designated as a substation of the Wisconsin Eye Bank. Dr. Orin A. Hermundstad, former Stoughton general practitioner who is currently an ophthalmology resident at University Hospitals in Madison, is chairman of the eye bank committee.

VOLUNTARY DUES ASSESSMENT

The Executive Committee reminds all Ophthalmologists that voluntary dues for the year 1968 are now being received. Voluntary contributions to the Section are used for projects specially designed to educate the public and others on medical eye care.

The regular voluntary membership contribution is $100. Educational membership contribution, for physicians who derive no part of their income from private practice, has been set at $50.

Please make your check payable to the Section on Ophthalmology and mail it to the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Geigy

New Superintendent UW Hospitals

Appointment of P. Whitney Spaulding as superintendent of University of Wisconsin Hospitals for the period of Sept. 1, 1968, to Aug. 31, 1969, was announced in early September.

Mr. Spaulding, who was associate executive director of Hartford Hospital, Hartford, Conn., has assumed the administrative leadership at University Hospitals while Edward J. Connors serves a one-year term as consultant to the Department of Health, Education and Welfare in Washington.

Approved by the Board of Regents was the promotion of James W. Varnum to the post of associate superintendent. Mr. Varnum has been on the administrative staff of the hospitals since 1964, most recently as an assistant superintendent.

Mr. Spaulding, 39, is a native of Hartford and received his B. A. degree from Amherst College, and a master's degree in public health from the University of Pittsburgh. An air force veteran, he had been on the administrative staff of Hartford Hospital since 1960.

Mr. Varnum received his bachelor's degree from Dartmouth College and his master's degree in hospital administration from the University of Michigan. He completed his administrative residency at University Hospitals before joining the staff as administrative assistant in 1964.

Patio Cookout at St. Luke's Hospital

A patio cookout at St. Luke's Hospital in Brookfield provided 45 patients and a number of staff members from the physical medicine and rehabilitation department with a special activity. Occupational therapists worked with psychiatric patients in preparing the food. A group of six young girls presented a variety of songs. The socializing and change of routine were among the benefits of this and other outdoor events which are under the direction of *Dr. Edwin C. Welsh*, Wauwatosa, director of the physical medicine and rehabilitation department.

Fall Clinic at Columbia Hospital

The fall clinic program of Columbia Hospital, Milwaukee, was held Sept. 10, using the general theme of "Therapeutic Dilemmas," a title which is used by *Dr. Harry Beckman* in publishing a regular series of articles in the WISCONSIN MEDICAL JOURNAL. Faculty of the Marquette School of Medicine and members of the Columbia Hospital medical staff participated in the program which was supported in part by the Wisconsin Regional Medical Program as well as Columbia Hospital and Marquette School of Medicine.

Physicians whose names appear in italics are members of the State Medical Society.

American Medical Technologists in Wisconsin

The annual business meeting of the Wisconsin State Society of American Medical Technologists will be held Nov. 2 at Chilton. This will include election of officers, annual reports, presentation of the Award to the Outstanding Hospital Administrator of the Year, and a Distinguished Achievement Award.

Marquette–Jackson Clinic Meeting

The thirty-eighth annual Marquette–Jackson Clinic postgraduate meeting was held Oct. 2 at the Park Motor Inn in Madison. Members of the Marquette School of Medicine and medical staff members of Jackson Clinic participated in the program which was climaxed with an evening dinner at which *Dr. Gerald A. Kerrigan*, dean of Marquette School of Medicine, spoke to the group about the recent events and plans of the medical school. The program was supported in part by the Merck Sharp & Dohme Foundation.

Medical Technology Course in Colorado

The University of Colorado School of Medicine will present a program on "Medical Technology" May 12–16, 1969, at the YMCA Conference Center, Estes Park, Colo. The seventh postgraduate course in Medical Technology is designed primarily for the medical technologist and will consist of plenary sessions and discussion seminars. Many outstanding guest speakers will participate.

Juvenile Amputee and Congenital Limb Deficiency Center

MILWAUKEE CHILDREN'S HOSPITAL

The Amputee and Limb Deficiency Center is a diagnostic clinic for the evaluation and treatment of acquired and congenital deficiencies throughout the state of Wisconsin. An orthopedic surgeon, prosthetist, registered nurse, occupational therapist, physical therapist, social worker, and a representative of the Bureau for the Handicapped Children comprise the clinic. Upon completion of their evaluation of each case, a summary of the findings and recommendations are transmitted to the referring physician or agency. Director: Alfred E. Kritter, MD.

Children up to sixteen years of age and of all economic levels are welcome at the clinic which is located at 1700 West Wisconsin Avenue, Milwaukee [tel. (414) 344–7100, ext. 372], but they must be referred by a physician or an appropriate referral agency.

The YMCA Conference Center, a rustic mountain retreat, borders the Rocky Mountain National Park and is located 70 miles northwest of Denver and 4½ miles from the village of Estes Park at an altitude of 8,000 feet.

A detailed program and housing information will be available about Feb. 1, and will be sent only to those who write a letter indicating their intention to register. The course is limited to 500 registrants. Tuition and registration fees for the five days: $75.00. Cosponsored by the Colorado Society of Medical Technologists and the Office of Postgraduate Medical Education—2736, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

NEW SCIENTIFIC JOURNAL ON STROKE TO BE ISSUED BY HEART ASSOCIATION

The American Heart Association has announced that it will publish a new scientific journal entitled "Stroke—A Journal of Cerebral Circulation."

The publication will be the first to bring together the laboratory and clinical research being conducted in the many areas of medicine which touch on the cause, prevention and treatment of cerebrovascular disease, and the rehabilitation of stroke patients. It also will report studies on the circulation of blood to the brain.

Both the American Academy of Neurology and the American Neurological Association have agreed to cooperate with the American Heart Association in the publication of the journal.

Initial publication date has not yet been set, but the journal will subsequently be issued every two months. The project, which reflects the widening responsibility of the Heart Association to stroke patients and to physicians treating stroke, was proposed by AHA's Council on Cerebrovascular Disease and approved by the Board and Publications Committee of the Association.

Appointment of an editor and editorial board for the new publication will be announced at a later date.

Further information concerning "Stroke—A Journal of Cerebral Circulation" may be obtained from the Publishing Department, American Heart Association, 44 East 23rd Street, New York, N.Y. 10010.

* * *

EVERYBODY HAS limitations, but what really counts are the abilities that remain. . . . Dr. Clarence D. Selby, first medical director of General Motors Corporation.

AMA News Notes on VOLUNTEER PHYSICIANS FOR VIET NAM

At the close of the fiscal year 1968 (July 1, 1967 through June 30, 1968), 483 physicians had served 60-day service tours under this voluntary program. Over a three-year period, these physicians contributed more than 80 man-years of voluntary service. In effect, an average of 30 physicians has been maintained in Viet Nam at all times since the American Medical Association became responsible for this program in the summer of 1966.

These U.S. licensed physicians were recruited from 49 states, the District of Columbia, the Canal Zone, and from seven overseas areas. Wisconsin contributed seven physicians in fiscal year 1967 and five physicians in 1968. Only 12 other states surpassed Wisconsin in total number of physicians volunteering.

It has been estimated that one out of every 650 U.S. licensed physicians has participated in this program. Thirty-two physicians are needed every 60 days to maintain this program. Most needed are general practitioners, internists, pediatricians, and general surgeons, with an immediate demand for orthopedic surgeons and ophthalmologists.

Interested physicians should contact: Director, AMA Volunteer Physicians for Viet Nam, AMA, 535 North Dearborn St., Chicago, Ill. 60610.

AMERICAN ACADEMY OF CLINICAL TOXICOLOGY FORMED

The American Academy of Clinical Toxicology has been founded for the advancement of clinical toxicology, a medical specialty concerned with the diagnosis and treatment of poisoning and drug intoxication.

The purposes of the Academy are to encourage clinical investigation, to promote the development of diagnostic and therapeutic methods, to foster among practicing physicians a better understanding of the treatment of poisoning, and to improve the medical care received by the poisoned patient.

Five categories of membership are provided: fellowship, active members, associate members, honorary, and sustaining members.

The Academy will provide its members with a suitable periodical for the publication of original contributions to clinical toxicology. An active program of continuing education will be pursued by the Academy to provide the physician in practice with opportunity for specialized training in the management of poisoning.

An organizational meeting of the American Academy of Clinical Toxicology is planned for Oct. 22 from 9:00 to 12:00 a.m., Drake Hotel, Chicago, Ill. Applications for charter membership and further information may be obtained from: Eric G. Comstock, MD, Acting Secretary-Treasurer, AACT, P.O. Box 2565, Houston, Tex. 77001.

OBITUARIES

Dr. Jamil T. LaHam, 79, former Winneconne physician, died July 11, 1968, in Ripon.

Doctor LaHam graduated from the St. Louis College of Physicians and Surgeons in 1918, attended the University of Paris, University of Maryland, and the Marquette University School of Medicine. He was a former chief of staff at Ripon Municipal Hospital.

Surviving are his widow; three sons, Jamil, Antigo, Stan, Aurora, Ill., and Dr. Quentin, Quebec, Canada; and one daughter, Antoinette, Miramar, Fla.

Dr. James P. Dean, 79, prominent Madison surgeon died July 21, 1968, in Madison.

Born in Madison, Doctor Dean was one of the founders of the Dean Clinic and practiced until 1949 when he retired because of ill health. He graduated from the University of Pennsylvania in 1913 and interned at New York City Hospital. He served in the United States Army Medical Corps in World War I.

Doctor Dean was a past president of the Dane County Medical Society, a member of the State Medical Society of Wisconsin, American Medical Association, the American Board of Surgery, and the American College of Surgeons.

Surviving are his widow, Maude; two daughters, Mrs. Richard (Doris) Keeley and Mrs. Dean (Patricia) Bloodgood, Madison; two sons, Dr. James L., Madison, and Dr. David L., Woodland Hills, Calif.

Dr. Carroll Rice, 76, former Delavan physician, died July 23, 1968, in Danville, Ill.

Doctor Rice practiced in Delavan until 1944 when he moved to Rockford, Ill. He graduated from the Loyola University Medical School in 1915.

Surviving are his widow, Leona; a daughter, Mrs. Robert Smith, Rockford; and a son, Arden, St. Petersburg, Fla.

Dr. T. Charles Hemmingsen, 78, Racine physician for 50 years, died Aug. 9, 1968, in Racine.

Doctor Hemmingsen graduated from the Marquette University School of Medicine in 1918, and interned at Allied Hospital, New York. He was a member of the United States Navy Medical Corps from 1918–1919. Doctor Hemmingsen served as chief of staff at St. Luke's Hospital, Racine, from 1929 to 1939 and is a former president of the Racine County Medical Society. He served as a councilor of the State Medical Society of Wisconsin from 1946 to 1954 and in 1968, at the State Society's annual meeting, he was honored for his 50 years in the practice of medicine. He was also a member of the American Medical Association.

Surviving are his widow, Pearl; and a son, Charles J. of Winchester, Mass.; and a daughter, Mrs. Janet A. Bartos of Milwaukee.

Dr. Harold A. Bachhuber, 63, Sauk City physician for 36 years, died Aug. 10, 1968, in Sauk City.

Doctor Bachhuber graduated from the University of Wisconsin Medical School in 1929 and interned at St. Mary's Hospital, Madison. Doctor Bachhuber was a former member of the State Board of Health and also served as a president of the Sauk County Medical Society.

He was a member of the State Medical Society of Wisconsin and American Medical Association.

Reprinted with permission from MARSHFIELD NEWS–HERALD, August 19, 1968

Dr. Roy P. Potter

In the passing of Dr. Roy P. Potter Sunday morning, Marshfield lost the patriarch of the medical profession here and the community now mourns the last of the six practitioners who established the Marshfield Clinic 52 years ago.

But although the Clinic, with its 80 doctors, is now one of the city's greatest assets, those who are saddened by Dr. Potter's death mourn the man because of what he was, rather than because of what he helped to create.

Roy Potter was a farm boy, a native of Mauston, and he never lost the friendly, unassuming manner that comes naturally to rural people. On becoming a physician he practiced for a short time in Friendship and then for a few years in Auburndale, before coming to Marshfield in 1910.

It was here, of course, that he joined with Drs. K. W. Doege, V. A. Mason, W. G. Sexton, H. H. Milbee and William Hipke to form the Clinic which today serves a broad area of Wisconsin and enjoys a nationwide reputation.

Dr. Potter chose radiology as his specialty and he was president of the Clinic from 1934 to 1940. A pioneer in his field, he was one of the founders of the Wisconsin Radiological Society. He remained active in his profession into his eighties.

The career of this hard-working country doctor encompassed a period during which the medical profession made greater progress in the treatment of disease than it had achieved in all the years before. It was Dr. Potter's privilege, therefore, to play an active role in the most progressive era his profession had known.

Throughout his 65 years as a doctor, he remained a warm and friendly neighbor to all who knew him, a healer whose genuine interest in his fellow man shone from his countenance for all to see. The memory of his friendship will continue to be cherished by the many who were bathed in its light.

Surviving are his widow, Effie; and three sons, John, Sauk City; Dr. David, Washington, D. C.; and Richard, Los Angeles, Calif.; and a daughter, Mrs. William R. Hudson, Prairie du Sac.

Dr. Roy P. Potter, 89, the last surviving founder of the Marshfield Clinic, died Aug. 18, 1968, in Marshfield.

Doctor Potter received his medical degree from the Milwaukee Medical College in 1903 and opened his office in Auburndale, Wis. He remained there until 1910 when he established a practice in Marshfield with Dr. H. A. Lathrop, who died the following year. In 1916, he founded the Marshfield Clinic with six other doctors who had gone into specialty fields. Doctor Potter chose radiology and went to Chicago to take training. He was one of the founders of the Wisconsin Radiology Society, a fellow of the American College of Radiology, and a member of the Radiological Society of North America, and the American Board of Radiology.

Doctor Potter served as president of the Marshfield Clinic from 1934 to 1940 and assumed a semi-retired status in 1945 and retired officially in 1959. For many years of his semi-retirement he continued duties which he began in 1922 as physician at the Wood County Hospital.

In 1953, Doctor Potter was honored by the State Medical Society of Wisconsin for his 50 years of medical practice. He was also a member of the Wood County Medical Society and American Medical Association.

Surviving is his widow, Helen, and a nephew, Dr. Robert B. Potter, Minneapolis, Minn.

Dr. Sidney P. Hurwitz, 51, Milwaukee, died Aug. 24, 1968, in Milwaukee.

Doctor Hurwitz graduated from Rush Medical College, Chicago, in 1941 and served his internship at Mount Sinai Hospital. He served his residency at University Hospitals, Madison. Doctor Hurwitz was affiliated with the staffs of Mount Sinai, Deaconess, Doctors, Trinity, and County General hospitals in Milwaukee. He was an assistant clinical professor in the department of urology at Marquette School of Medicine. Doctor Hurwitz was a diplomate of the American Board of Urology and a past president of the Wisconsin and Milwaukee County Urological associations. He was also a member of the American Urological Association and a member of its North Central section executive committee.

Doctor Hurwitz was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Marilyn; and two sons, Richard and James, and a daughter, Linda.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison, Wisconsin 53701.

Interprofessional Code

An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

Guide to The Service Corporation Law

A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

Code of Necropsy Procedure

A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

Hearing Conservation Programs for Wisconsin Industries

Some recommended standards and principles for providing a hearing conservation program in industry.

Occupational Health, A Guide for Medical and Nursing Personnel

General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

New expanded edition—$5.00 with binding, $4.00 without binding. Ideal for any industrial plant with nurse service.

Find Your Future in the Health Field

A career guide (the health careers brochure).

Guide to Immunization Planning

An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

Inspection of Medical Records

An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

Principles for Transporting the Ill and Injured

A guide for providing emergency transportation services, including model community and state ordinances.

School Vision Screening Program

An outline to facilitate the development of a program to detect significant visual defects among school children.

First Aid Chart

Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959

Relating to fee splitting between physicians and others.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF SEPTEMBER 13, 1968

NEW MEMBERS

Alberti, John B., 8700 West Wisconsin Ave.. Milwaukee 53226
Atamdede, Yasar I., 3333 South 27th St., Milwaukee 53215
Carter, Thomas L., 925 Mound St., Madison 53715
Connally, Joseph M., Jr., 2441 Fontain Circle, Madison 53713
Crumpacker, Margaret, Evangel Medical Center, 222 Argyle, Kowloon, Hong Kong
Davasligil, Halil, Hustisford 53034
Davis, Hugh L., Jr., 647 Crandall, Madison 53711
Donovan, Timothy Jay, 1300 University Ave., Madison 53706
Evans, William E., 8700 West Wisconsin Ave., Milwaukee 53226
Friedman, Jerry E., 2040 West Wisconsin Ave., Milwaukee 53233
Froelich, Ralph D., 301 Troy Dr., Madison 53704
Gulyn, Bohdan E., 318½ Scott St., Wausau 54401
Harris, John A., 1111 Delafield St., Waukesha 53186
Hassler, Robert E., 1114 10th St., Monroe 53566
Hart, Terrence N., 17000 West North Ave., Brookfield 53005
Herman, La Vern H., 217 Wisconsin Ave., Waukesha 53186
Jackson, Robert D., 6601 Inner Drive, Madison 53705
Krapohl, Andrew J., 516 Houston St., Marinette 54143
Leben, Carol D., 10625 West North Ave., Milwaukee 53226
McCarthy, Thomas M., 2 West Gorham St., Madison 53703
Paetkau, Margaret E., 726 West Main St., Madison 53715
Pruscha, Calman S., II., 2040 West Wisconsin Ave., Milwaukee 53233
Ramirez, Guillermo, 1300 University Ave., Madison 53706
Reeb, Kenneth G., 1552 University Ave., Madison 53705
Skinner, H. Grant, 440 Hillington Way, Madison 53705
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Veranth, Jerome J., 5200 Washington Ave., Racine 53406

REINSTATED

Johnson, Frances, 425 East Wisconsin Ave., Milwaukee 53202

CHANGES OF ADDRESS

Ackermann, E. J., Milwaukee, to 12835 N. Colony Dr., Mequon 53092
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Bentley, John D., Madison, to Glenn Turner Clinic of Internal Medicine, Professional Bldg., Springfield, Mo., 65806
Blahnik, Clarence L., St. Louis, Mo., to 5527 Starlit Dr., Mehlville, Mo. 63129
Blatnik, Donald S., Staten Island, N. Y., to 10625 W. North Ave., Wauwatosa 53226
Bornstein, Samuel L., Hallandale, Fla., to 6265 Sand Beach Rd., Oconomowoc 53066
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Chicks, Calvin O., 152 S. Locust, Janesville 53545
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Harned, Roger K., 1924 14th Ave., Monroe 53566
Herhahn, Frank T., Madison, to 8407 E. Lehigh, Denver, Colo. 80237
Holl, John W., No. Manchester, Ind., to 3817 Corina Way, Palo Alto, Calif. 94303
Jaques, Darrell A., El Paso, Tex., to Walter Reed General Hospital, Washington, D.C. 20012
Just, John F., Brookfield, to 1111 Delafield St., Waukesha 53186
Killins, Wendell A., Green Bay, to 47 De Mesa Carmel, Carmel, Calif. 93921
Kinsey, Jack L., Groton, Conn., to 510 North Power St., Spring Valley, Ill. 61362
Kirsch, John M., New Berlin, to 814 Hawthorne Ave., Elmhurst, Ill. 60126

Klatt, Kenneth M., Madison, to P. O. Box 4233, Rockford, Ill. 61110

Klopfer, William P., Wauwatosa, to 963 N. Woodlawn Dr., Thousand Oaks, Calif. 91360

Kohn, Samuel E., 6161 N. Berkeley Blvd., Milwaukee 53217

Kreitzer, Frank V., 9315 Harding Blvd., Milwaukee 53226

Kurtz, Esther Caldwell, 4001 Mineral Point Rd., Madison 53705

Leite, Joaquim, 3199 So. 83rd St., Milwaukee 53219

Mackey, James P., Green Bay, to Oak Ridge Circle, R.R. 2, De Pere 54415

Maguire, Dennis W., 2415 Adler Circle, Middleton 53562

Martens, William E., Wauwatosa, to 10425 W. North Ave., Milwaukee 53226

Martineau, Edward L., 1301 E. Olive, Milwaukee 53211

McCormick, Michael R., Portsmouth, R. I., to 102 E. Main St., Waukesha 53186

Melms, Frederick A., Jr., 1113 River Heights Rd., Menomonie 54751

Morter, Howard V., 407 W. Silver Spring Dr., Milwaukee 53217

Ottensmeyer, David J., Route 4, Sugar Bush Lane, Marshfield 54449

Pellicer, Joseph G., Schofield, to Woodlawn, Washington 98764

Peterman, Mynie Gust, 4141 Ardmore Ave., Milwaukee 53211

Pisciotta, Anthony V., Milwaukee County General Hosp., 8700 W. Wisconsin Ave., Milwaukee 53226

Propeck, Stephen L., Wauwatosa, to 636 St. John's Rd., Woodstock, Ill. 60098

Raasch, H. Marilyn, 1127 E. Del Mar Blvd., Pasadena, Calif. 91106

Reynoso, Gustavo, Cudahy, to Roswell Park Memorial Institute, 666 Elm St., Buffalo, New York 14203

Rian, Oliver, Sturgeon Bay, to 4819 Grandview Dr., Peoria Heights, Ill. 61614

Richards, Robert N., Marshfield, to 1815 Chestnut St., Grand Forks, North Dakota 58201

Schlichting, Johanna E., 49 Reid Terrace, Apt. 20, Fond du Lac 54935

Shearer, Thomas M., 1011 N. Main St., Edgerton 53534

Snider, Gordon L., Wood, to V.A. Hospital, 150 S. Huntington Ave., Boston, Mass. 02130

Speckhard, Mark E., Dyess AFB, Tex., to 2331 N. 86th St., Milwaukee 53226

Stageman, John F., Milwaukee, to 1700 W. High Dr., Jackson, Mich. 49203

Suechting, Ralph L., 116 S. Commercial St., Neenah 54956

Thranow, John A., P. O. Box 575, La Belle, Fla. 33935

Tweeten, John B., Menomonie, to c/o Richard Kieles, 5141 13th Ave., S., Minneapolis, Minn. 55417

Vermund, Halvor, Madison, to 1210 Sand Point Way, Corona del Mar, Calif. 92625

Wear, John B., Jr., 448 University Hospitals, 1300 University Ave., Madison 53706

Wirka, Herman W., Jr., Alhambra, Calif., to 1601 Marengo, So. Pasadena, Calif. 91030

Wright, W. E., Lock Box 90, Mondovi 54755

Wunsch, Charles A., Wauwatosa, to 5836 W. Lisbon Ave., Milwaukee 53210

REMOVED FROM MEMBERSHIP

Anderson, Fin G., Eau Claire–Dunn–Pepin County, resigned

Aronson, Willard, Eau Claire–Dunn–Pepin County, removed per County Secretary

Beltran, D. J., Milwaukee County, transferred to California

Earnhart, Harlan, Eau Claire–Dunn–Pepin County, resigned

Haukohl, Robert S., Milwaukee County, transferred to Florida

Knight, Curtis C., Dane County, transferred to Arizona

Olson, Neiland R., Milwaukee County, transferred to Colorado

Propeck, Stephen L., Milwaukee County, transferred to Illinois

Raasch, H. Marilyn, Milwaukee County, transferred to California

Schutz, Weston J., Dodge County, removed per County Secretary

DEATHS

La Ham, Jamil T., non-member, July 11, 1968

Davin, Charles C., Kenosha County, July 25, 1968

Hemmingsen, T. Charles, Racine County, Aug. 9, 1968

Bachhuber, Harold Alfred, Sauk County, Aug. 10, 1968

Potter, Roy P., Wood County, Aug. 18, 1968

Hurwitz, Sidney P., Milwaukee County, Aug. 24, 1968

Fowler, Paul H., Sauk County, Aug. 28, 1968

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BOOKSHELF

BOOKS RECEIVED

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706

SYSTEMIC MYCOSES

Ciba Foundation Symposium, edited by G. E. W. Wolstenholme and Ruth Porter. Little, Brown, & Co., Boston, July 1968. 287 pages. Price: $12.

GROWTH OF THE NERVOUS SYSTEM

Ciba Foundation Symposium, edited by G. E. W. Wolstenholme and Ruth Porter. Little, Brown, & Co., Boston, July 1968. 295 pages. Price: $12.

AGE ON THE DEATH CERTIFICATE AND MATCHING CENSUS RECORD—United States—May–August 1960

U. S. Department of Health, Education and Welfare. Public Health Service. Series 2, No. 29. U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 53 pages. Price: 45¢.

MEDICAL X-RAY VISITS AND EXAMINATIONS DURING PREGNANCY—U. S. 1963

U. S. Department of Health, Education and Welfare. Public Health Service. Series 22, No. 5. U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 41 pages. Price: 40¢.

SPARE-PART SURGERY—The Surgical Practice of the Future

By Donald Longmore. Doubleday Science Series, Doubleday & Company, Inc., Garden City, New York, 1968. 192 pages. Price: $5.95.

MODERN TREATMENT

Vol. 5, No. 4. Treatment of Fluid and Electrolyte Imbalance, guest editor, David D. Thompson, M. D.; and Current Treatment of Clinical Tetanus, by Norman A. Christensen, M. D., and Deloran L. Thurber, M. D. Hoeber Medical Division, Harper & Row, Publishers, 49 E. 33 Street, New York, N. Y. 10016. 1,500 pages annually. Subscription, $16.00 per yr.

CURE FOR CANCER—A National Goal

By Solomon Garb, M. D., F.A.C.P., professor of pharmacology; associate professor of Community Health and Medical Practice, University of Missouri School of Medicine. Published by Springer Publishing Company, Inc., 200 Park Ave., South, New York, N. Y. 10003. 1968. 309 pages. Price: $6.75.

QUARTERLY JOURNAL OF STUDIES ON ALCOHOL

Published by the Journal of Studies on Alcohol, Inc. at Rutgers Center of Alcohol Studies, New Brunswick, N. J. PART A, Originals and PART B, Documentation. One year subscription $15.00. Single copy, $4.50. Published in March, June, Sept. and Dec.

ELECTROCARDIOGRAPHIC NOTEBOOK (third edition)

By M. Irene Ferrer, M. D., clinical professor of medicine, Dept. of Medicine, Columbia University College of Physicians and Surgeons. Published by Hoeber Medical Division, Harper & Row, Publishers, 49 E. 33rd St., New York, N. Y. 10016. 1968. 141 pages.

THE 1968 REVISION OF THE STANDARD CERTIFICATES

U. S. Department of Health, Education and Welfare. Public Health Service. Series 4, No. 8, U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 47 pages. Price: 40¢.

HOW TO LIVE WITH HYPOGLYCEMIA

By Charles Weller, M. D. and Brian Richard Boylan. Published by Doubleday & Company, Inc., Garden City, New York. 1968. 130 pages. Price: $4.50.

PUBLIC HEALTH REPORTS

U. S. Department of Health, Education and Welfare. Public Health Service. Vol. 83, No. 7, July 1968. U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 626 pages. Price: $.55 per copy or $5.25 a year.

INFANT LOSS IN THE NETHERLANDS

U. S. Department of Health, Education and Welfare, Public Health Service. Series 3, No. 11, U. S. Government Printing Office, Superintendent of Documents, Washington, D. C. 20402. 63 pages. Price: 50¢.

MODERN TREATMENT

Vol. 5, No. 2, Treatment of Parkinson's Disease and Allied Disorders, guest editor, Warren V. Huber, M. D.; and Treatment of Acquired Hemorrhagic Disorders, guest editor, Oscar D. Ratnoff, M. D. Hoeber Medical Division, Harper & Row, Publishers, 49 East 33 St., New York, N. Y. 10016. Published bimonthly. 1,500 pages annually. Subscription: $16.00 per yr.

MODERN TREATMENT

Vol. 5, No. 3. Treatment of Gallbladder Disease, guest editor, James B. Carey Jr., M. D., Ph. D. and Treatment of Menopausal Problems, guest editor, Eugene J. Cohen, M. D. Hoeber Medical Division, Harper & Row, Publishers, 49 East 33 St., New York, N. Y. 10016. Published bimonthly. 1,500 pages annually. Subscription: $16 per yr.

BOOK REVIEWS

SYNOPSIS OF DERMATOLOGY

By William D. Stewart, M.D., clinical instructor in dermatology, University of British Columbia Faculty of Medicine, and associate in dermatology, Vancouver General Hospital, British Columbia; Julius L. Danto, M.D., visiting staff, St. Paul's and St. Vincent's hospitals, Vancouver; and Stuart Maddin, M.D., visiting staff, St. Paul's Hospital, Vancouver. C. V. Mosby Co., St. Louis. 1966. 664 pages. Price: $10.85.

Synopsis of Dermatology by Stewart, Danto, and Maddin, is a compilation of: (1) the essentials of diagnosis, (2) the minimum of histopathology and pathogenesis, and (3) the best of therapy. The chapters on Embryology, Anatomy, and Physiology of the skin provide an easily readable basis for the understanding of the remainder of the book. The chapter on regional diagnosis is the highlight of the book. It lists the regional distribution of disease with a brief description of each. The other chapters cover disease entities in a general way. The many colored plates are exceptionally well reproduced and

add much to the book while the black and white reproductions are fair to good.

This book will adequately satisfy most readers with accurate, practical, and concise (albeit sometimes too brief) essentials of cutaneous diseases. It is directed to the medical student, intern, neophyte resident in Dermatology, and the practicing nondermatologist for whom it should serve as a good reference book.—MARVIN H. MARGOLIS, M.D.

THE VISUAL FIELD

A textbook and atlas of clinical perimetry. By David Oliver Harrington, 2d ed., St. Louis, Mo., Mosby Co., 1964, pp. 386, illus. Price: $16.00.

This book is a comprehensive up-to-date volume on methods and findings in visual field examinations. It presents visual field findings in specific diseases and also presents the findings that occur with lesions at specific locations in the visual system. Its illustrations are excellent and it is concise, clear, and well written. This book will primarily be of interest to ophthalmologists, neurologists, and neurosurgeons.—JAMES C. ALLEN, M.D.

THIAMINE DEFICIENCY

Ciba Foundation Study Group No 28, edited by G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown & Co., Boston, 1967, 163 pages.

In November 1966 nineteen members of a study group discussed *Thiamine Deficiency:* Biochemical Lesions and their Clinical Significance. The contributors are recognized experts in biochemistry. While most of the reports have to do with biochemical studies, several of them would be of interest to physicians who are interested in thiamine deficiency. —ROBERT F. SCHILLING, M.D.

NEW HOPE FOR YOUR SKIN

By Irwin I. Lubowe, M.D., F.A.C.A., associate dermatologist at Metropolitan Hospital Center and at Flower and Fifth Avenue Hospital, New York. Pocket Books, Inc., New York. May 1966. 264 pages. Price: 75¢.

This pocket book provides interesting and newsy reading for a person with some basic knowledge about medical terms and disease. It is too technical in most areas for the average child, teenager, or adult. In a book dealing with every day skin problems there is no place for a disease like lupus erythematosus which is not a common disease. There are certain statements that this reviewer finds hard to accept. The diet restrictions for acne vulgaris are too stringent and lack scientific support. Boric acid solution is not an antiseptic though it has been used extensively for years as one. The use of injections of vaccines prepared from food to desensitize an individual having food allergy is poor advice, and one which has many dangers. If chlorophyll is as good for odorous feet as the author would make one believe then barnyards should be sweet. The statement that syphilis is responsible for 15% of blindness is misleading and untrue.

Chapter XVI on clean and healthy skin and chapter XXIII on the skin and poisonous plants were particularly informative and should be of great help to anyone needing this type of information.

The removing of hair growing from moles by clipping with a scissors is to be singled out because of its importance in preventing pathological changes. I find it difficult, on the other hand, to apply this same advice of the author to a wart which in my experience never has hair.

Most of the material in the appendix and glossary will confuse the average non-medical person and has no place in a book of this order.

The book is easy reading for a physician, particularly a dermatologist, and should be of help in some instances. It could be used as a reference book by the lay person. Certain chapters would lend themselves well to a class in health education taught in a high school or even a college level. The illustrations are good and do help the reader who has no knowledge about the anatomy or pathology of the skin. Although the book is more technical than it need be for the average reader, I feel that it may serve well as a semi-nontechnical medical guide for those interested in healthy and attractive skin.—STURE A. M. JOHNSON, M.D.

DEVELOPMENT OF THE LUNG

Ciba Foundation Symposium, edited by Anthony de Reuck and Ruth Porter. Little, Brown & Co., Boston, 1967. 408 pages. Price: $13.

This volume presents the deliberations of a distinguished group of biological scientists assembled by the Ciba Foundatiton to discuss the fundamental aspects of the development of the lung. Brief papers by each of the participants cover a wide variety of subjects bearing on the phylogeny or ontogeny of the lung. Following each of these presentations the reader will find a lively discussion, noteworthy because of the range of observations made on many members of the animal kingdom. Examples of intriguing bits of knowledge to be discovered in these brilliant discussions are: The giraffe if pressed to run at 30 miles an hour will collapse and become cyanotic presumably due to pulmonary edema. The diving seal develops large oxygen debt which on surfacing is not repaid as measured by present methods.

The practicing physician will find much basic knowledge well presented although sometimes rather complex. Photographic illustrations, line drawings, and graphs are helpful in presentation of the material. The descriptions of the extensive evolutionary problems which arise during the change from aquatic life to land and air breathing sharpens one's understanding of the physiology of respiration, especially diffusion of gases. After contemplating the many questions posed in the discussion sections, the physician will realize that there are limitations in our present knowledge which when finally elucidated may improve our present concepts of therapy.

This small book will be widely read and consulted by those interested in the physiology and mechanism of respiration at the eventful time of birth.—JOHN K. CURTIS, M.D.

MEDICAL PHARMACOLOGY: PRINCIPLES AND CONCEPTS (third edition)

By Andres Goth, M.D., C. V. Mosby, St. Louis, Mo., 1966, 636 pages. Price: $12.50.

In the face of growing knowledge about drugs and toxins, a brief book on pharmacology is a risky venture. I do not believe that Doctor Goth has succeeded. This new edition of *Medical Pharmacology* offers selected facts rather than overall concepts. Arbitrary dosages are listed, giving a false sense of comprehensiveness which the book does not deliver. The telegraphic style is more like a digest than a book of "principles and concepts." Within six pages, for example, the author mentions seventeen antihistaminics, annotating each with a phrase. This space could be replaced with a table for completeness, and text for emphasis. Other examples abound.

In general, the more complete texts, edited as they are with large type for essentials and small type for details, are the most valuable for both reference and perspective.—THEODORE L. GOODFRIEND, M.D.

SYNOPSIS OF OBSTETRICS

By Charles E. McLennan, M.D., professor of gynecology and obstetrics, Stanford University School of Medicine, Palo Alto, Calif. Seventh edition. C. V. Mosby Co., St. Louis. 1966 471 pages. Price: $6.85.

Basic facts of obstetrics are well covered. Easy reading and accurate information. No advantage over other synopses available. Main value—for Medical Student review.—BEN M. PECKHAM, M.D.

PRIMER ON PREMATURITY AND HIGH-RISK PREGNANCY

By S. Gorham Babson, M.D., associate professor of pediatrics, University of Oregon Medical School, and director of premature nursery, Doernbecher Memorial Hospital for Children, Portland, Ore.; and Ralph C. Benson, M.D., professor and chairman, department of obstetrics and gynecology, University of Oregon. C. V. Mosby Co., St. Louis. 1966. 194 pages. Price: $10.50.

This book is a concise, schematic treatment of conditions in pregnancy which are associated with high risk for the fetus. The material is covered in an extremely superficial way. Several statements made are quite open to question:

P. 19—(1) Large placentas have more reserve than smaller ones.

P. 19—(2) Placental oxygen transfer diminishes with placental aging. Evidence available points the other way.

P. 20—(3) Maternal colpocytology offers a reliable index of placental insufficiency.

This book does not seem to me to have any value for the practicing obstetrician. Perhaps its main utility would be as a quick reference source for medical students.—LUIS B CURET, M.D.

OBSTETRICS AND GYNECOLOGY

By J. Robert Willson, M.D., professor of obstetrics and gynecology, University of Michigan Medical School, and chairman of the department of obstetrics and gynecology, University of Michigan Medical Center, Ann Arbor; Clayton T. Beecham, M.D., director of gynecology and obstetrics, Geisenger Medical Center, Danville, Pa.; and Elsie Reid Carrington, M.D., research professor of obstetrics and gynecology, Woman's Medical College of Pennsylvania, Philadelphia. C. V. Mosby Co., St. Louis. Third edition. 1966. 776 pages. Price: $15.50.

The third edition of *Obstetrics and Gynecology* by Willson, Beecham, and Carrington is an expansion of a mimeographed summary of obstetrics and gynecology for medical students. The authors present a broad base of information concerning all the emotional and physiological phases of reproduction. Physiology, diagnostic procedures, preventive measures, emotional growth, and psychosexual problems are emphasized.

This book is a good introduction to obstetrics and gynecology. It would be a valuable addition to the library of the medical student, the general practitioner, family physician, and specialist. Much of the material has been rewritten and is up-to-date. The illustrations and tables are excellent.—M. J. THORNTON, M.D.

DISEASES OF THE UVEAL TRACT

Vol. IX—System of Ophthalmology. Edited by Sir Stewart Duke-Elder, G.C.V.O., F.R.S., and Edward S. Perkins, Ph.D., M.D., F.R.C.S., Institute of Ophthalmology, University of London. C. V. Mosby Co., St. Louis. 1966. 978 pages. Price: $44.50.

This volume is a survey of the world's literature on diseases of the uveal tract. It covers the history, clinical findings, pathophysiology, and treatment of every known uveal tract disease. It is very well illustrated and contains many colored pictures. The book is an excellent source of references on any disease of the uveal tract.

Most ophthalmologists will want this book in their library.—JAMES C. ALLEN, M.D.

ATLAS OF DIAGNOSTIC TECHNIQUES AND TREATMENT OF RETINAL DETACHMENT

By William H. Havener, BA, MD, MS (ophth.), professor, dept. of Ophthalmology, Ohio State University, and Sallie Gloeckner, Medical Artist. Published by C. V. Mosby Co., St. Louis, Mo., 200 pages. Price: $18.00.

The first part of this book is devoted to diagnostic techniques in examination of retinal detachment patients. Use of the indirect ophthalmoscope is emphasized. The author then describes the surgical techniques he uses in doing retinal detachment surgery. The techniques he describes are based on his experience in doing over 375 retinal detachment operations each year. This book is very well illustrated with drawings on almost every other page.

This book is especially informative for ophthalmology residents who are starting their training with the indirect ophthalmoscope in retinal detachment surgery. It will also be of interest to other ophthalmic surgeons doing retinal detachment surgery.—JAMES C. ALLEN, M.D.

PHYSICIANS EXCHANGE

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Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 67, No. 11 NOVEMBER 1968

SCIENTIFIC ARTICLES

Ophthalmopathy with Hypothyroidism, by George W. Dean, M.D., Milwaukee ---- 547

Werner's Syndrome, by Palmer G. Tibbetts, M.D., Harold D. Rose, M.D., and David W. Kersting, M.D., Milwaukee ---- 550

Family Outbreak of *Mycoplasma Pneumoniae*, by Paul M. Cox, Jr., M.D. and H. Grant Skinner, M.D., M.P.H., Madison ---- 558

Therapeutic Dilemmas: Complicated Rheumatoid Arthritis (No. 13 of a Series), by Harry Beckman, M.D., Milwaukee ---- 561

Comments on Treatment: Current Management of Multiple Myeloma, by Donald R. Korst, M.D., Madison ---- 566

SPECIAL FEATURES

Official Call for Scientific Exhibits: 1969 Annual Meeting ---- 12

Annual Photography Contest: 1969 Annual Meeting ---- 14

Complications of Radical Neck Dissection (abstract) ---- 549

Penalties of Progress: Drug-Induced Hematologic Disease (abstract) ---- 549

Antilymphocyte Serum ---- 549

Primary Aldosteronism (abstract) ---- 560

Excessive Use of Tetanus Toxoid Boosters (abstract) ---- 568

The Gift Book, by Virginia Holtz, Madison ---- 574

EDITORIALS

President's Page: A Successful Venture with Youth, by William D. James, M.D., Oconomowoc ---- 569

Discerning Benevolence ---- 570

New Combo ---- 571

The Enigma of Exophthalmos, by Leslie G. Kindschi, M.D., Monroe ---- 572

The Honorable Oscar Rennebohm ---- 572

REGULAR FEATURES

Publication Information ---- 6

Medical Meetings ---- 7

Medical Student Forum ---- 573

Medical Green Sheet ---- 577

Physician News ---- 45

County Societies ---- 55

Specialty Societies ---- 61

Section on Ophthalmology ---- 63

Obituaries ---- 65

Society Records ---- 68

Wisconsin Physicians Service ---- 72

Physicians Exchange ---- 74

Index to Advertisers ---- 76

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Journal
Established 1903

Annual Subscription ---- $10.00
Single Copy ---- 1.50
Previous Years' ---- 3.00
January Blue Book ---- 5.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago, Illinois 60610; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin 54481.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.

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Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 NEIGHBORING STATES

Dec. 7–12: Annual meeting, American Academy of Dermatology, Palmer House, Chicago, Ill.

1968 OTHERS

Dec. 1: Annual meeting, American College of Nutrition, Hilton Plaza Hotel, Miami Beach, Fla.

Dec. 2–6: "Physical Methodology in Medical Research," American College of Physicians, Massachusetts Institute of Technology, Cambridge, Mass.

Dec. 9–12: Pacific Cancer Conference, American Cancer Society, Hawaiian Division, Honolulu, Hawaii.

Dec. 10–13: "Cardiology—1968," Institute for Cardiopulmonary Diseases of Scripps Clinic and Research Foundation, American College of Cardiology, La Jolla, Calif.

Dec. 13–15: "Advances in Coronary Artery Disease," American College of Cardiology, Waldorf–Astoria Hotel, New York, N.Y.

1968 AMA

Dec. 1: Tenth National Conference on the Medical Aspects of Sports, AMA, Hotel Deauville, Miami Beach, Fla.

Dec. 1–4: Clinical Convention, AMA, Miami Beach, Fla.

1969 NEIGHBORING STATES

April 20–25: 50th Annual Session, American College of Physicians, Conrad Hilton Hotel, Chicago, Ill.

Apr. 30–May 4: M.A.C. VI-Midwest Anesthesiology Conference, Illinois Society of Anesthesiologists, Palmer House, Chicago.

June 10–13: Annual convention, Catholic Hospital Association, Minneapolis, Minn.

1969 OTHERS

Jan.: AHA Council on Clinical Cardiology—"Cardiopulmonary Physiology," San Francisco, Calif.

Jan. 12–17: Annual meeting, Society for Cryosurgery, Hilton Plaza, Miami Beach, Fla.

Jan. 27–29: Annual session, International Medical Assembly of Southwest Texas, San Antonio, Tex.

Feb. 3–5: Sectional meeting, American College of Surgeons, featuring general surgery, urology, orthopedics, Fontanelle Hotel, Omaha, Neb.

Feb. 8–13: Annual Congress and Teaching Seminar, International Academy of Proctology, Hollywood Beach Hotel and Country Club, Hollywood, Fla.

Feb. 21–22: Postgraduate continuation course in Gastroenterology, Institute of Gastroenterology, Good Samaritan Hospital, and VA Hospital, Del Webb TowneHouse, Phoenix, Ariz.

Feb. 24–26: Sectional meeting, American College of Surgeons, featuring gynecology-obstetrics, neurosurgery, general surgery, and symposium on trauma, Brown Hotel, Louisville, Ky.

Mar. 10–12: Joint meeting for doctors and nurses, American College of Surgeons, featuring general surgery and eight surgical specialties, Sheraton–Boston Hotel, Boston, Mass.

Mar. 28–30: International Congress (Giornate Mediche Internazionali) featuring molecular pathology, endoscopy, blood circulation and respiratory apparatus, and psycho-pharmaceutics, Istituti Ospitalieri of Verona (Italy).

Mar. 31–Apr. 2: Psychiatry and the Internist (20th symposium), Hahnemann Medical College and Hospital, Philadelphia, Pa.

Apr.: AHA Council on Clinical Cardiology—"Clinical Electrocardiography and Vectorcardiography," Augusta Ga.

Apr. 18: Annual symposium on Infectious Diseases, American Academy of General Practice, Battenfield Auditorium, Kansas City, Kan.

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

May 8–10: National Conference on Breast Cancer, American Cancer Society, Shoreham Hotel, Washington, D.C.

June: AHA Council on Clinical Cardiology, title and location to be announced.

July 7–11: Postgraduate Course—Clinical Electrocardiographic Interpretation, Hahnemann Medical College and Hospital, Philadelphia, Pa.

July 14–18: Postgraduate course—Interpretation of Cardiac Arrhythmias, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 11–17: Postgraduate course—Space Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium), Hahnemann Medical College and Hospital, Philadelphia, Pa.

Winter: AHA Council on Clinical Cardiology—"Clinical Use of Cardiovascular Drugs," La Jolla, Calif.

1969 AMA

July 13–19: Annual meeting, American Medical Association, New York City.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

1970 OTHERS

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

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MEDICAL MEETINGS *continued*

AMA Clinical Convention, Dec. 2–4

Scientific sessions of wide medical interest are planned for morning and afternoon Monday through Wednesday, Dec. 2–4, at the American Medical Association's 22nd Clinical Convention in Miami Beach, Fla.

Morning topics Dec. 2 include the anemias, thrombophlebitis, and obstetrics. The afternoon program includes discussion of white cell disorders and diseases of the lymph nodes, management of claudication, cerebral ischemia due to neck vessel occlusion, and gynecology.

Tuesday, Dec. 3, topics are cardiology, gastrointestinal diseases, proctology, and—in the afternoon—new approaches in cardiology, bacterial skin infections, and the skin and sunlight.

Discussions on sex will be held Wednesday morning, Dec. 4, to include such topics as marital problems, changing sex values, pre-adolescent and adolescent sex education, and sex and the senior citizen. Hypertension and the kidney also will be studied at the morning session.

Wednesday afternoon's topics include pulmonary diseases, respiratory ills in children, and more on the kidney.

Scientific sessions will be held in Miami Beach Convention Hall. Total registration is expected to be about 10,000, including 4,500 physicians; 300 medical students, nurses, and members of allied medical professions; 800 industrial exhibitors; and 4,400 guests of physicians and exhibitors.

The Oct. 21 issue of *The Journal of the American Medical Association* will carry the Scientific Program for the Clinical Convention.

National Conference on Breast Cancer

The National Conference on Breast Cancer will be held at the Shoreham Hotel in Washington, D.C., Thursday–Saturday, May 8–10, 1969. A multidisciplinary review of the breast cancer problem in the United States will be presented including epidemiology, etiology, detection, diagnosis, management, and control measures. Disappointing as well as successful approaches in combatting the disease will be discussed in an effort to identify possible directions for future progress.

For further information write: Roald N. Grant, MD, National Conference on Breast Cancer, American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

All members of the medical and related professions, and research investigators are invited to attend this Conference. There is no registration fee. Preregistration is requested.

International Diabetes Federation

The VII International Congress of Diabetes will be held in Buenos Aires, Argentina, Aug. 23–28, 1970, as a special homage to Professor Bernardo A.

Houssey, according to an announcement by Virgilio G. Foglia, MD, president of the Federation, who may be contacted at Paraguay 2155 7th Floor, Buenos Aires, for further details.

Southwest Texas Medical Assembly

The 33rd annual session of the International Medical Assembly of Southwest Texas, will be held in San Antonio, Tex., Jan. 27–29, 1969, at San Antonio's new convention center. Eighteen guest speakers from the United States and Mexico will present topics in the following specialties: anesthesiology, dermatology, internal medicine, general practice, neurosurgery, obstetrics and gynecology, ophthalmology, otolaryngology, orthopedic surgery, pathology, pediatrics, proctology, radiology, and surgery.

In addition to the scientific program, there will be many social events for the physician and wife. Sports events include golf, tennis, and skeet. Also a post convention trip to Guadalajara and Puerto Vallarta has been planned. Those interested in receiving further information or registering may write to Dr. Joaquin B. Gonzalez, President, or Mr. S. E. Cockrell, Jr., Executive Director, 202 West French Place, San Antonio, Tex. 78212.

Pacific Cancer Conference in Hawaii

The Pacific Cancer Conference of the American Cancer Society, Hawaiian Division, will present a program on "Newer Concepts of Chemotherapy in Cancer" Dec. 9–12 at the Hilton Hawaiian Village, Honolulu, Hawaii.

Wisconsin leaders in cancer therapy play a major role in the program. Guest speakers are: Fred J. Ansfield, MD, Anthony R. Curreri, MD, Charles Heidelberger, PhD, Sanford Mackman, MD, and Halvor Vermund, MD, of the University of Wisconsin; and John S. Stehlin, Jr., MD, Baylor U. College of Medicine; and Jesse L. Steinfeld, National Cancer Institute. There also are several Hawaiian speakers on the program.

For further details and reservations, write or phone: American Cancer Society, Hawaii Division, Inc., Hotel and Travel Reservation Office, 230 North Michigan Ave., Chicago, Ill. 60601; tel. 372–8302.

AMA Conference on Rural Health

The Council on Rural Health of the American Medical Association will present the 22nd National Conference on Rural Health Mar. 21–22 at the Philadelphia Marriott Motor Hotel, Philadelphia, Pa. Theme: Meeting Rural Health Needs in our Changing Times.

Purposes of the conference: To develop effective planning methods for community health services. To discuss effective ways for delivery of health services in rural areas. To review methods for efficient utilization of health resources. To study community organization for meeting health needs.

The major dinner event will be Friday evening at which time Dr. Henry Brill of West Brentwood, N.Y., will address the guests on the subject "A

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Medical Directors Meeting in Florida

The first scientific conference of the International Society of Medical Directors in Chronic Disease Facilities will be held Dec. 5 at the Hilton Plaza Hotel, Miami Beach, Fla., following the AMA Clinical Conference.

The Society was founded Nov. 30, 1967, in Houston, Tex., to fulfill an apparent and expressed need of medical and paramedical professionals dealing with the chronically ill. The Society has inaugurated a five-year plan which includes as its objectives: basic research into the aging process, investing in preventive medical measures, establishing alternatives to isolated and separated housing developments for the elderly, and repair of existing delapidated houses.

Inquiries may be directed to: Patricia Dorr, Executive Director, ISMDCDF, Suite 1003/360 North Michigan Ave., Chicago, Ill. 60611; tel. 346–7133.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF OCTOBER 1968

1 Wisconsin Work Week of Health (WWW/H)
1 Surgical Staff, Madison Gen. Hosp.
1 Madison Urological Society
1 Madison Anesthesiology Society
1 Board of Trustees, Dane Co. Med. So.
2 WWW/H
2 SMS Commission on Safe Transportation
3 WWW/H
3 Executive Committee, CES Foundation (Pomainville Award)
4 WWW/H
8 Annual Meeting, Dane Co. Med. Soc.
9 SMS Committee on Occupational Health
10 Ninth Councilor District, Wisconsin State Dental Society
11 Cancer Study Committee, Wisconsin Regional Medical Program
14 Advisory Committee on Extended Care Facilities, Dane Co. Med. Soc.
16 Faculty Committee and Junior Students, Univ. of Wisconsin Medical School
16 Planning Committee, Wis. Regional Medical Program
17 SMS Division on Alcoholism and Addiction
17 Madison Area Radiologists
19 Executive Committee, SMS Council
19 SMS Council
19 Board of Trustees, CES Foundation
20 SMS Council
21 American Board of Internal Medicine Examination
23 Cardiology Study Committee, Wis. Regional Medical Program
25 SMS Commission on Scientific Medicine (Gundersen Award Presentation)
30 SMS Commission on Hospital Relations and Medical Education
30 Planning Committee, Wis. Regional Medical Program
31 SMS Division on School Health

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Continuation Course in Gastroenterology

The Institute of Gastroenterology, Good Samaritan Hospital, and the Veterans Administration Hospital in Phoenix are co-sponsoring a postgraduate continuation course in Gastroenterology in Phoenix, Ariz., Feb. 21–22, 1969, at the Del Webb Towne-House.

Purpose of this course will be to relate current physiological knowledge and newer diagnostic techniques to clinical gastroenterology with particular attention toward the therapy of the disease.

Further information and registration forms may be obtained from Dr. David C. H. Sun, Good Samaritan Hospital, Phoenix, Ariz. 85002.

MONOGRAPHS: SELF-HELP DEVICES/ORTHOTICS

Two publications relating to self-help devices and orthotics have been published by the Institute of Rehabilitation Medicine, a part of the New York University Medical Center.

A guide to articles and other publications on these topics, Rehabilitation Monograph XXXV is entitled *Bibliography on Self-Help Devices and Orthotics, 1950–1967*. Primarily for occupational therapists, the publication is intended to be a fairly comprehensive listing of material published on these subjects over the 18-year period in both professional and general interest publications.

Rehabilitation Monograph XXXVI, *Rehabilitation Equipment and Devices Constructed in Wood*, contains photographs and detailed diagrams and instructions for making therapeutic exercise equipment, daily living assistance devices and occupational therapy projects.

While the publication on equipment and devices is intended primarily for professional use, it could also be recommended to families of handicapped people as a guide to constructing practical devices for use, exercise and recreation in the home.

Copies of the monographs may be purchased at $2.00 each from the Publications Office, Institute of Rehabilitation Medicine, 400 East 34 Street, New York, N. Y. 10016. Checks should be directed to the Publications Office and made payable to New York University Medical Center.

Dr. Blount Returns From Orient

Dr. Walter P. Blount, Milwaukee, recently returned from the Orient where he read papers at the meetings of the International Society for the Rehabilitation of the Disabled and the Western Pacific Orthopaedic Association at Hong Kong and lectured at the University of Hong Kong, the University of Kyoto, and the University of Tokyo.

Dr. Hofmeister Elected President

Dr. Frederick J. Hofmeister, chairman of the Department of Obstetrics and Gynecology at Lutheran Hospital of Milwaukee, was elected president of The Central Association of Obstetricians and Gynecologists Sept. 28, 1968, at the meeting in Oklahoma City, Okla. It is the first time that a Milwaukee obstetrician and gynecologist has received this national honor. The region over which Doctor Hofmeister is president encompasses 28 central states. Membership in the Association is limited to 500 practicing obstetricians and gynecologists, but has an additional 300 life memberships—many of whom are prominent obstetricians and gynecologists —both clinicians and academicians representing the central region.

Dr. Wasserburger in Symposium

Dr. Richard H. Wasserburger, Madison, recently took part in the first Great Plains Regional Professional Education Symposium at Minneapolis, Minn. The topic of study was "Cardiovascular Disease."

Named to Mental Health Clinic

Dr. O. G. Moland, Augusta, recently was named to the Board of Directors of the Eau Claire County Mental Health Clinic.

Dr. Lyne Joins Methodist Hospital

Dr. Benjamin W. Lyne recently joined the Methodist Hospital, Madison, as chief pathologist. Doctor Lyne graduated from the University of Wisconsin Medical School and took a pathology residency at the Mayo Clinic, Rochester. He was associate pathologist at Little Company of Mary Hospital, Evergreen Park, Ill., before accepting the position as chief pathologist at Methodist.

Dr. Fernando Joins Marshfield Clinic

Dr. Oscar Fernando recently joined the staff of the Marshfield Clinic at Marshfield. Doctor Fernando, a neurosurgeon, graduated from the University of Santo Tomas in 1958 and interned at The Grace Hospital, Detroit, Mich. He taught anatomy at Wayne State University Medical School in Detroit and spent four years of residency in neurosurgery alternating between Wayne State University, a neurosurgery clinic in Helsinki, Finland, and a year in missionary medicine with the Grenfell Mission in Labrador and Newfoundland.

Dr. Hobbins Named Chairman

Dr. William B. Hobbins, Madison, recently was named chairman of the Dane County chapter of the American Cancer Society.

Dr. Weeth Heads Cancer Unit

Dr. John B. Weeth, La Crosse, recently was elected president of the La Crosse Cancer Unit, Wisconsin Division of the American Cancer Society. Doctor Weeth is associated with the Gundersen Clinic.

Dr. Schoofs Joins Medford Clinic

Dr. Greg G. Schoofs has joined the medical staff of the Medford Clinic. Doctor Schoofs graduated from Northwestern University, Evanston, Ill., in 1965 and interned at St. Luke's Hospital, Kansas City, Mo. He served as a flight surgeon in the United States Army and was stationed in Vietnam.

Dr. Baldwin Guest Speaker

Dr. Robert C. Baldwin, Watertown, recently was the guest speaker at the Watertown Memorial Hospital Auxiliary meeting. He spoke on heart transplantation.

Dr. King Joins Clinic Staff

Dr. Douglas King, West Scotland, recently joined the staff of the Marshfield Clinic at Marshfield as a specialist in radiology. Doctor King graduated from Trinity College, and Dublin University receiving his medical degree in 1954. He interned at Shotley Bridge General Hospital, Durham, England, and at Tynemouth Infirmary in Northumberland, England. He was in general practice in Newfoundland for four years, and later became registrar at Newcastle upon Tyne, a regional radiotherapy center, for over two years. Doctor King was at the Radium Institute at Liverpool, England, for one year and a radiotherapist at St. John's Hospital in Newfoundland for a year before joining the Ontario Cancer Research Foundation at Hamilton, Ont., Canada, for four years.

Dr. Clemons Joins Gundersen Clinic

Dr. John E. Clemons recently joined the medical staff of the Gundersen Clinic, La Crosse, in the Department of Otolaryngology and Maxillofacial Surgery. Doctor Clemons graduated from the University of Wisconsin Medical School in 1962 and took a year of internship and two years of general

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Physicians whose names appear in italics are members of the State Medical Society.

surgery training at Lutheran Hospital, La Crosse. He spent three years of specialty training in ear, nose, and throat and maxillofacial surgery at the State University of Iowa in Iowa City.

Dr. Block Affiliates with Webster Clinic

Dr. Robert T. Block recently became affiliated with the Webster Clinic, Green Bay. He interned at Milwaukee County Hospital and worked as a staff physician at Mendota State Hospital, Madison. From 1964–1966, he took up his residency at St. Paul–Ramsey Hospital, St. Paul, Minn., and in 1966 he was a medical fellow at the University of Oklahoma, Oklahoma City, until 1968.

Dr. Young Opens Office

Dr. E. W. Young, Platteville, recently opened his office to specialize in internal medicine including cardiology and allergy. Doctor Young graduated from the College of Medicine at the University of Illinois and interned at Milwaukee County Hospital. He spent three years in the 41st Field Hospital in the South West Pacific and for three years was a resident physician at the University of Illinois Hospital, Chicago. He practiced for five years at Elm Street Clinic, Sycamore, Ill., and 10 years at the Carbondale Clinic, Carbondale, Ill., before opening offices in Platteville.

Attend Anesthesiology Meeting

Drs. Betty J. Bamforth, Nancy Wu, George E. Webb, and Marcial Zamora of the Department of Anesthesiology, University of Wisconsin Medical School, Madison, attended the annual session of the American Society of Anesthesiologists in Washington, D. C. Oct. 19–23.

Dr. Stripling Joins Clinic

Dr. Burnell D. Stripling recently became associated with the Marinette Medical Clinic, Marinette. He graduated from the New York Medical College, interned and took residency at the Los Angeles County Hospital from 1960 to 1964. He then practiced in Colorado Springs, Colo., for two years and served in the United States Navy at Great Lakes for two years.

Physicians Participate on Panel

Drs. Richard W. Edwards, Richland Center; *Robert M. Green*, La Crosse; *George G. Griese*, Marshfield; and *L. M. Pippin*, Richland Center, who was the moderator, recently participated on the Heart Forum panel held in Richland Center. The forum was sponsored by the Cardiac Consultation Clinic Committee of the Wisconsin Heart Association. The topics that were discussed included "Environmental Management of the Heart Patient at Home and Work," "What is a Heart Attack?,"

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Four Physicians Added to Staff

West Allis Memorial Hospital recently announced the addition of four members to its staff. They are *Drs. Terrence Hart, Palmer G. Tibbetts, Yasar Atemdede* and *Donald S. Blatnik, Sr.*

Doctor Hart graduated from Ohio State University Medical School and served his internship and residency at Milwaukee County Hospital. He specializes in internal medicine.

Doctor Tibbetts graduated from the University of Wisconsin Medical School and served his internship at Madison General Hospital and his residency at Milwaukee County Hospital. His specialty is dermatology.

Doctor Atemdede is a graduate of the University of Istanbul Medical School, Turkey, and served his internship at Flower Hospital, Toledo, Ohio. His residency in obstetrics and gynecology was taken at Mt. Sinai Hospital and St. Luke's Hospital in Milwaukee.

Doctor Blatnik graduated from Marquette University School of Medicine and interned at Milwaukee County Hospital and served his residency at VA Hospital, Wood. He will specialize in otolaryngology.

Dr. Hiatt Associates with Clinic

Dr. Edwin Hiatt is now associated with the Lakeland Medical Associates in Minocqua. He received his medical degree from the Indiana University Medical School and served his internship at Riverside County General Hospital and University Medical Center, Riverside, Calif. He took a pathology residency at General Rose Memorial Hospital, Denver, Colo., before coming to Minocqua.

Dr. Malewiski Heads Alcoholism Council

Dr. Larry J. Malewiski, Sheboygan, recently was elected president of the Sheboygan County Council on Alcoholism. He was elected to a one-year term.

Dr. Zlatnik Guest Speaker

Dr. Philip A. Zlatnik, Manitowoc, recently was the guest speaker before the staff of the Sheboygan Memorial Hospital. Doctor Zlatnik, whose talk was sponsored by the Wisconsin Heart Association, spoke on the "Artificial Pacemaker."

Dr. Diego Joins Hospital Staff

Dr. Benito B. Diego recently became associated with the medical staff of St. Francis Hospital, La Crosse, as chief anesthesiologist. He graduated from Central Manila University in 1954 and in 1957 he came to the United States and served an internship at St. Francis Hospital. Doctor Diego took several residencies at various hospitals including a one-year residency in anesthesiology at the University of Minnesota.

Dr. Austad Named to Arthritis Group

Dr. William R. Austad, formerly of Monroe, recently was elected a member of the Board of the Arthritis Foundation of El Paso, Tex. Doctor Austad is presently serving as a captain with the United States Army at William Beaumont Hospital, El Paso. After his tour of duty, he will resume his duties at The Monroe Clinic in the practice of internal medicine and rheumatology.

Dr. Meli Elected President

Dr. J. V. Meli, Oshkosh, recently was elected president and chief of staff at Mercy Medical Center, Oshkosh. Doctor Meli joined the Mercy staff in 1940. Other officers elected were: *Drs. M. G. Apell*, vice-president and president-elect, and *R. F. Douglas*, secretary. *Dr. D. B. Becker* was named chief of medical services, with *Dr. J. B. Hughes* as his alternate. *Dr. J. A. Leschke* and *Dr. R. C. Wolfgram*, past president, were named chief and alternate in obstetrics and gynecology services. *Dr. W. E. Clark* was reappointed chief of surgery, with *Dr. E. F. Cummings* again serving as his alternate. Elected to the executive committee as members-at-large are *Dr. C. I. Bowerman, Dr. W. V. Hahn, Dr. R. W. Roberts*, and *Dr. R. D. Neubecker.*

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Dr. Mueller Opens Meeting

Dr. Gilbert F. Mueller, Jr., Appleton, who recently returned from a tour of duty with the Ship HOPE in Ceylon, told of his experiences before the first meeting of the season for the Fox Valley Academy of Medicine. The Academy was formed three years ago for the primary purpose of bringing the doctors in the area together primarily for educational purposes. Doctor Mueller is president for the coming year and *Dr. John E. Mielke*, Appleton, vice-president; and *Dr. Paul N. Gohdes*, Neenah, secretary.

Dr. Shealy Receives Research Grant

Dr. C. Norman Shealy, La Crosse, recently received a $2,500 grant to continue his research on parkinsonism. Doctor Shealy, chief of neurosurgery at the Gundersen Clinic, received the grant from the Research and Education Fund of the Schweppe Foundation, Chicago. It will be used in conjunction with an earlier grant from the Boothroyd Foundation and money supplied by the Adolf Gundersen Medical Foundation.

Dr. Klieger Featured in Milwaukee Journal

Dr. Jack A. Klieger, Milwaukee obstetrician, recently was featured in the "Picture Journal Section" of the MILWAUKEE JOURNAL. Doctor Klieger was graduated from the Marquette University School of Medicine. In addition to his many duties as a physician practicing alone, Doctor Klieger is also associate clinical professor of obstetrics at Marquette School of Medicine.

Drs. Ali and Savetamal Join Clinic

Drs. Masroor Ali and Charoen Savetamal recently joined the staff of Medical Associates of Beaver Dam, Service Corporation. Doctor Ali is qualified for the American Board of Surgery and is fellow of the International College of Surgeons. He has been a lecturer in anatomy at the Northwestern Medical School in Chicago and had previously been on the medical staff at the Waupun Clinic.

Doctor Savetamal graduated from the University of Medical Sciences at Bangkok, Thailand, and served his internship at St. Thomas Hospital at Akron, Ohio. He took residencies at Grace Hospital and Cleveland Metropolitan General Hospital. Before joining Medical Associates, he was in the practice of urology at Beckley, W. Va.

Dr. Malit Opens Office

Dr. Benito B. Malit recently opened his office in Horicon. He graduated from Manila Central University in 1958 and in 1959, he came to the United States, spending one year of rotating internship at the South Chicago Community Hospital. He then became a resident in general surgery at the Alexian Brothers Hospital and at St. Elizabeth Hospital,

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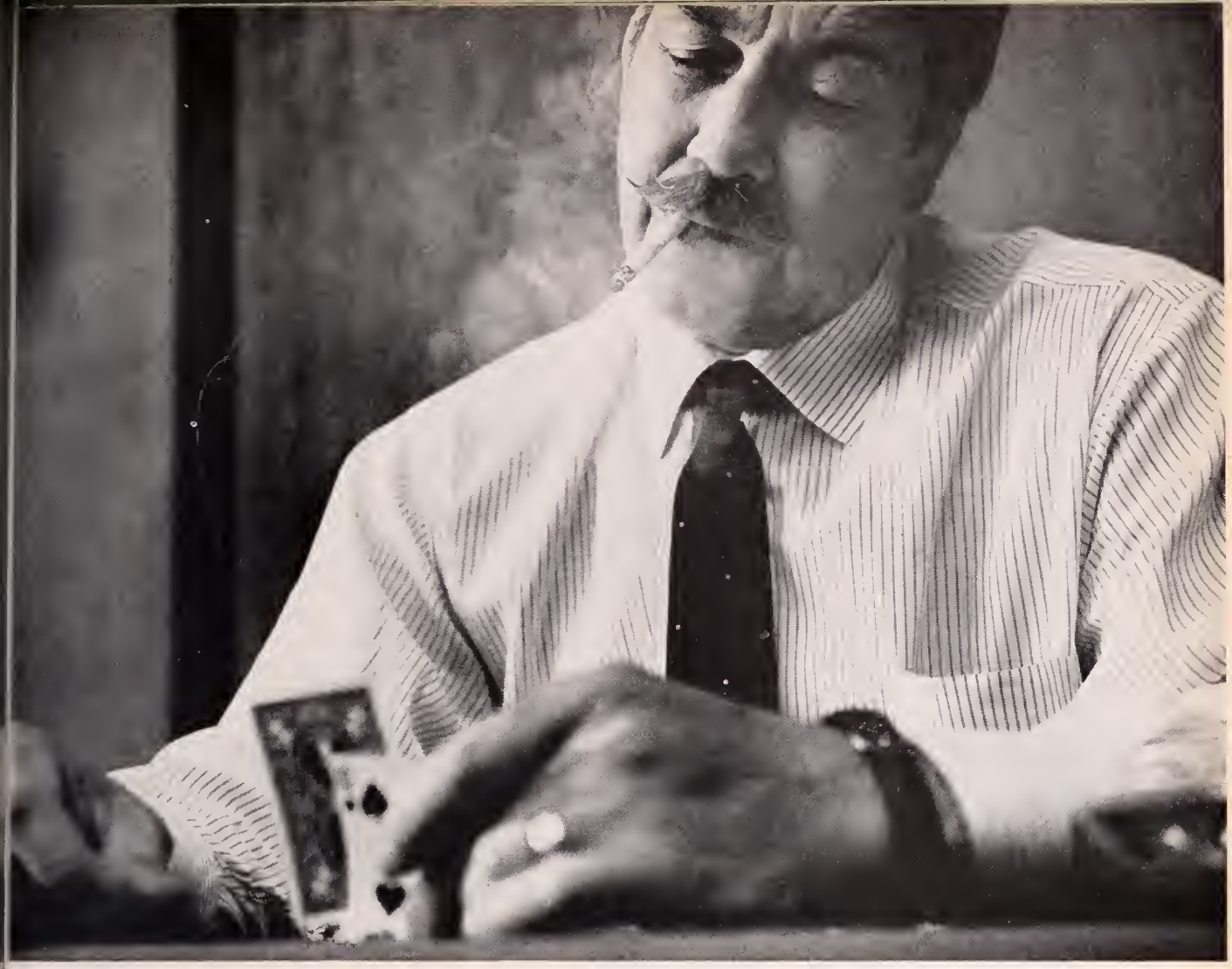

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Chicago. Doctor Malit's wife is also a physician, graduating from the University of Santo Tomas in The Philippines. She also completed her residency in internal medicine at St. Mary's Medical Center, San Francisco, and will join her husband in practice in the near future.

Dr. Flavio Puletti Receives Second Annual Gunnar Gundersen Award

The 1968 Gunnar Gundersen Gold Medallion Award was presented to *Dr. Flavio Puletti* at a special ceremony at the State Medical Society headquarters in Madison Oct. 25. The presentation was made during a dinner meeting of the Commission on Scientific Medicine.

The award to Doctor Puletti recognizes him for his "outstanding teaching exhibit" at the State Medical Society's annual meeting last May. The exhibit, entitled "Stereotactic Surgery in Parkinson's Disease," was judged the best by Wisconsin physicians who reviewed all exhibits.

GUNNAR GUNDERSEN GOLD MEDALLION AWARD winner, *Dr. Flavio Puletti* (second from right) of Madison, accepts medallion award from *Dr. William D. James* (left) of Oconomowoc, president of the State Medical Society, while *Dr. E. S. Gordon* of Madison, chairman of the Commission on Scientific Medicine, and *Dr. E. J. Nordby* (right) of Madison, chairman of the Council, look on.

The Gundersen Award was established in 1966 during the State Medical Society's 125th anniversary to honor Dr. Gunnar Gundersen of La Crosse, former president of the State Medical Society and the American Medical Association.

The award is given each year at the Society's annual meeting. The first person to receive the award in 1967 was *Dr. Joseph Darin*, an assistant professor of surgery at Marquette School of Medicine.

Doctor Puletti, who is an associate professor of surgery at the University of Wisconsin Medical School, received his medical degree from the University of Florence, Italy, in 1947, and was a resident in neurological surgery at University Hospitals in Madison from 1952 to 1956.

Dr. Holmgren Featured in Newspaper

Dr. Luther E. Holmgren, Madison, senior member of the department of surgery and chairman of the board of directors of the Jackson Clinic, recently was featured in "Know Your Madisonian" in the WISCONSIN STATE JOURNAL. Doctor Holmgren is active in community affairs and has been with the Jackson Clinic since graduating from the University of Michigan Medical School in 1934. Doctor Holmgren is a past president of the Dane County Medical Society.

Dr. Kohn Starts "Young Adult" Clinic

After 40 years of practice in pediatrics, *Dr. Samuel E. Kohn* of Milwaukee has retired from that practice to establish Milwaukee's first clinic for "young adults" in their teens. At age 66, Doctor Kohn has no intention of retiring so now he will devote the rest of his years in active medicine toward a group "that has been sort of lost, children from 13 to 18, or 19." According to Doctor Kohn the clinic will be developed in collaboration with a large medical group in Milwaukee.

As a member of Milwaukee Children's Hospital since 1927, Doctor Kohn will serve as general chairman of the 75th anniversary year of the hospital in 1969. Doctor Kohn has also taught at Marquette medical school for 30 years, with the rank of assistant clinical professor.

Milwaukee Psychiatrist Speaks to Nurses

Dr. Don H. Martin, clinical instructor in psychiatry at Marquette School of Medicine and consultant in psychiatry to Marquette University, was the keynote speaker at a recent meeting of the Missouri State Nurses' Association in Columbia, Mo., Sept. 22–24. Theme of the meeting was "Techniques of Intervention in Crisis Situations."

Doctor Martin discussed methods of approaching crisis situations in the various areas of medical practice and addressed himself especially to the current crisis involving the use of the "Drugs of Abuse" and some emotional factors disposing to such a resort.

Doctor Martin noted particularly the need for those allied with medicine to recognize the intricate and inevitable interaction of mind and body in illness and directed attention to the fact that while it is recognized that conflicts of an emotional nature are frequently expressed through somatic pathways, the impact that various physical illnesses may have upon the psyche is often ignored in the patient's overall care. It was his feeling that if due consideration were given to patients' emotional needs in their total care, albeit that they might be affected with an organic illness, their total management would be facilitated and their recovery expedited.

WAUKESHA

County Health Department Activities Aired

Members of the Waukesha County Medical Society and its Woman's Auxiliary met in Pewaukee Oct. 9. *Dr. Lyle D. Franzen* of Waukesha County Health Department brought the group up-to-date as to "happenings in health" in the county. They also heard both candidates of the Ninth Congressional District review current health programs of the country.

Waukesha's county health department was featured in the Sept. 23 issue of the RACINE JOURNAL–TIMES as part of a series of articles related to the current proposal for a county health department in Racine County. Waukesha County adopted a county-wide health department in 1960 after a five-year study which was conducted amid bitter controversies.

CHIPPEWA

Mayo Clinic Physician Speaks

Dr. Colum A. Gorman of the Mayo Clinic, Rochester, Minn., was guest speaker at the Oct. 1 meeting of the Chippewa County Medical Society. He spoke on the "Management of Thyroid Disorders."

LA CROSSE

Supports Fluoridation Campaign

Sixty-three members of the La Crosse County Medical Society met Sept. 16 in Onalaska. During the business meeting the Society voted a $1500 contribution in support of the fluoridation campaign.

COLUMBIA–MARQUETTE–ADAMS

Conduct Tuberculin Skin Tests

The Tri-County Medical Society in cooperation with the Columbia County Public Health Service in September conducted a tuberculosis testing clinic for school children in the first, fifth, and ninth grades.

VERNON

Asks County Aid for Red Cross

In a recent letter to the VIROQUA BROADCASTER–CENSOR *Dr. L. F. Gulbrandsen* explained the reasons for the Vernon County Medical Society's request for financial help for the Red Cross Bloodmobile program from the County Board. He emphasized that the Society's decision to help the Vernon County Chapter of the Red Cross liquidate its deficit was entirely voluntary. The action was conditioned by a number of factors which relate to the many years of unselfish service this chapter has given to the people of Vernon County, he stated.

The appeal was felt to be necessary since the Chapter had depleted its reserves over the last few years and currently has been running one year behind in its payments to the Badger Regional Blood Center. He concluded by saying, "We know it will be a sad day for all of us if the Red Cross Blood Bank has to be withdrawn from our Hospitals because of lack of financial support, when so many people have given their time and effort in the work of the organization, and have participated as donors in this great humanitarian venture."

RACINE

Urges Racine County Health Department

During public hearings on a proposed Racine County Health Department, the Racine County Medical Society has gone on record as supporting the proposal, according to *Dr. R. E. Skupniewicz*. Another spokesman for the Society, *Dr. W. H. Williamson*, in a speech to Burlington rotarians, stated that the proposed health department would cost county taxpayers about $415,000 a year, compared with the $350,000 it now costs to operate the City of Racine Health Department.

Both speakers lauded the City of Racine's health department but pointed out the deficiencies of health service in the rest of the county and the continuing population growth.

KENOSHA

See Film on Disorders of Heart Rhythm

Members of the Kenosha County Medical Society Oct. 3 viewed a new sound movie on disorders of heart rhythm, means of detection, mechanisms of the disorders, and their significance to the health of the patient. The presentation was made in conjunction with the recent crash-cart training and near-future opening of both Kenosha hospitals' coronary care units.

During the business session reports were given about the Kenosha Visiting Nurse services and eligibility of patients for extended care facility benefits under the Medicare law.

MARATHON

Community and Hospital Status Discussed

One large general hospital is necessary in cities of Wausau's size to avoid unnecessary duplication of services, according to Dr. Charles U. Letourneau who spoke in September to members of the Marathon County Medical Society and invited guests representing area hospitals and medical service groups.

Physicians whose names appear in italics are members of the State Medical Society.

The speaker is medical director of Oak Park Hospital and president of The Letourneau Associates, hospital counsellors, of Chicago.

"Duplication of expensive services is ridiculous," he said, and added, "Prestige is a prime factor in spawning the race to accumulate expensive equipment that will then lie idle 50 to 60 percent of the time." "If hospitals cannot coordinate their services the threat of federal intervention and the withdrawing of federal aid in new construction are present," he explained. And finally he emphasized the need for total community involvement in health care.

WINNEBAGO

Pediatric Urology Discussed

Members of the Winnebago County Medical Society met Oct. 3 in Menasha. The program concerned "Pediatric Urology" which was presented by *Drs. Safouh A. Atassi*, Neenah; *R. William Roberts*, Oshkosh; and *Timothy T. Flaherty*, Neenah.

DOUGLAS

Discuss State Medical Society Resolutions

At the September meeting of the Douglas County Medical Society, *Dr. Charles J. Picard*, Superior, delegate to the State Medical Society, reviewed resolutions and actions taken by the House of Delegates of the State Medical Society at the May annual meeting.

BARRON–WASHBURN–SAWYER–BURNETT

Chetek Medical Clinic Hosts Society

Drs. Fred M. Bannister, Joseph P. Bender, and D. B. Pierpont of the Chetek Medical Clinic were hosts to the Barron–Washburn–Sawyer–Burnett County Medical Society in September. Speakers were Dr. Stanley Goldberg of Minneapolis and Dr. Peter Bartzan of Duluth. Twenty-four physicians were present.

SAUK

Dr. James Discusses Medical Organizations

At the October 8 meeting of the Sauk County Medical Society in Spring Green *Dr. W. D. James* of Oconomowoc, president of the State Medical Society, spoke to the members on organization of the SMS, Wisconsin Regional Medical Program, and Comprehensive Health Planning.

ASHLAND–BAYFIELD–IRON

Dr. Emanuel Talks on Coronary Care Units

At the Oct. 9 meeting of the Tri-County Medical Society *Dr. Dean Emanuel* of Marshfield spoke on "Coronary Care Units in Small Hospitals" and *Dr. George Griese*, also of Marshfield, spoke on "Urinary Infections in Children."

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Wisconsin Academy of General Practice

The Wisconsin Academy of General Practice when it met in annual session Sept. 25–26 at Milwaukee urged the Wisconsin legislature to subsidize Marquette School of Medicine.

The Academy also asked the legislature to study a way to induce young doctors to stay in Wisconsin and practice in areas where physicians were lacking.

Dr. Anthony J. Sanfelippo of Milwaukee was named president-elect of the Academy. The new president is *Dr. Gerald J. Derus* of Madison.

Wisconsin Society of Anesthesiologists

The Wisconsin Society of Anesthesiologists, at its annual fall meeting at The Playboy Club–Hotel in Lake Geneva Sept. 14–15, elected the following officers: president—*Dr. Robert M. Schuyler*, Milwaukee; president-elect—*Dr. J. N. Pallin*, Fond du Lac; to the Board of Directors—*Dr. Sheldon Burchman* and Ernest Henschel, Milwaukee.

The scientific program at this meeting considered the problems of anesthesia and metabolism, halogenated anesthetics, regional anesthesia, dissociative anesthesia, and neuroleptanalgesia. Speakers included Dr. Timoteo L. Galvez, Madison; Drs. Edward A. Brunner and John W. Ditzler, Northwestern Medical School; Dr. Guenter Corssen, University of Alabama Medical School; and Dr. John P. Kampine, Marquette School of Medicine, Milwaukee.

Wisconsin Radiological Society

The nineteenth annual meeting of the Wisconsin Radiological Society was held at The Playboy Club–Hotel, Lake Geneva, Sept. 20–22. Guest speaker was Dr. Arthur R. Clemett, associate professor of radiology, Yale University Medical School. Doctor Clemett lectured on "Gastrointestinal Manifestations of Lymphosarcoma and Lymphoid Hyperplasia" and "Occlusion of the Portal Venous Circulation." At the annual banquet the main speaker was *Dr. J. Edwin Habbe*, Milwaukee, who spoke on "Early Radiology in Wisconsin: The First Thirty Years."

Dr. Robert Feulner, Waukesha, was elected president to succeed *Dr. Charles Benkendorf*, Green Bay. The other new officers are *Dr. Wayne Rounds*, Madison, president-elect; *Dr. Harold F. Ibach*, Milwaukee, vice-president; *Dr. Robert F. Douglas*, Neenah, secretary and treasurer. *Dr. Charles Benkendorf*, Green Bay; *Dr. Lawrence L. Larsen*, Milwaukee; and *Dr. Herbert M. Aitken*, Eau Claire, were elected to the Board of Directors. *Dr. Howard Mauthe*, Fond du Lac, was elected to the board of censors. *Dr. Leslie L. Jones*, Fond du Lac, and *Dr. Lawrence L. Larsen*, Milwaukee, will continue as councilors to the American College of Radiology. *Dr. Howard Bayley*, Beaver Dam, and *Dr. Loren Hart*, Green Bay, were reelected alternate councilors.

New members accepted into the society were *Drs. Tamnit Ansusinha* and *Ivan Knezevic* of Madison, *Drs. Theodore Keller* and *James Youker* of Milwaukee, *Dr. Timothy Flaherty* of Neenah, *Dr. John McManus* of Green Bay, and *Dr. William Swift* of Kenosha.

The program chairman was *Dr. Andrew Crummy* of Madison.

Milwaukee Academy of Medicine

Dr. William Dameshek, professor of medicine, Mt. Sinai Medical School and attending hematologist at Mt. Sinai Hospital, addressed members of the Milwaukee Academy of Medicine Oct. 15 at the University Club of Milwaukee. His subject was "Chronic Lymphocytic Leukemia—A Model of Abnormal Immunity."

Wisconsin Society of Internal Medicine

Dr. James W. Manier of Marshfield was elected president of the Wisconsin Society of Internal Medicine at its annual meeting in Oshkosh Sept. 12–14. He succeeds *Dr. Edward K. Ryder* of Madison.

Nearly 140 physicians attended the two-day scientific program.

Other newly elected officers are: president-elect, *Dr. George R. Barry, Monroe;* and secretary-treasurer, *Dr. Addis C. Costello*, Milwaukee. Two Council members were elected: *Dr. J. D. Struthers*, Wausau, and *Dr. John M. Irvin*, Monroe.

Committee chairmen appointed by Doctor Manier are: membership, *Dr. Francis N. Lohrenz*, Marshfield; medical practice, Doctor Costello, Milwaukee; program, *Dr. John M. Irvin*, Monroe; public relations, *Dr. George E. Owen*, Eau Claire; and constitution and bylaws, *Dr. Robert F. Madden*, Milwaukee.

A $600,000 program to improve the quality of care for coronary patients in Wisconsin was revealed in the course of the program by *Dr. Dean A. Emanuel* of Marshfield. He said, however, the program must first be approved by the federal Regional Medical Program.

Doctor Emanuel outlined a "most exciting" development in the program whereby a computer system involving various hospitals in the state would be set up to diagnose electrocardiograms. Hospitals would transmit readings from the EKG over phone lines. The cost of the EKG would be reduced by 33 to 50 percent, he said. There are problems in instituting the program, but it is in the planning stage and could be instituted before 1970, he added.

Another proposal included equipping a mobile unit and team for training nurses, physicians, and electronics technicians to staff coronary care units.

Physicians whose names appear in italics are members of the State Medical Society.

INCOMING OFFICERS chatted with outgoing officers of the Wisconsin Society of Internal Medicine and the American College of Physicians when the two groups met jointly Sept. 12–14 at Oshkosh. (L–R) Wisconsin Governor of the American College of Physicians, Dr. J. LeRoy Sims, Madison; President-elect of WSIM, Dr. James W. Manier, Marshfield; Wisconsin Governor-elect of the ACP, Dr. Herbert W. Pohle, Milwaukee; and immediate Past President of WSIM, Dr. Edward K. Ryder, Madison.

Another speaker, T. A. Duckworth, vice-president of Employers Insurance of Wausau and chairman of the Wisconsin Advisory Comprehensive Health Planning Council, told internists they should become involved in comprehensive health planning. Although the program is federally funded, its implementation has been left to local planning groups who must take the initiative and make the decisions, he explained. Mr. Duckworth said comprehensive health planning should include physical, social, mental, and environmental health. He added that "the way for you to keep socialized medicine out is to get into the community and help with the planning."

Meeting with the WSIM was the American College of Physicians. *Dr. J. Le Roy Sims* of Madison, ACP Governor for Wisconsin; *Dr. James A. Means*, Milwaukee; *Dr. John M. Irvin*, Monroe; and *Dr. James W. Manier*, Marshfield, were chairmen of the program committee.

ABSTRACTS/PROCEEDINGS: FOURTH WORLD CONGRESS OF ANAESTHESIOLOGISTS

The Excerpta Medica Foundation has announced publication of two volumes pertaining to the Fourth World Congress of Anaesthesiologists, London, Sept. 9–13, 1968.

ABSTRACTS. This volume contains 225 abstracts of papers presented at the Congress. It is available at the price of $10.50 (postpaid).

PROCEEDINGS. The proceedings will be available in a clothbound, illustrated volume of approximately 1,100 pages. It will be published in Fall 1969. Price has not yet been established.

To obtain these publications, contact Excerpta Medica Foundation, Herengracht 119–123, Amsterdam, The Netherlands.

Dr. James Expresses Importance of Medical Record Librarians

Too much praise cannot be given to our medical record librarians who are often overlooked when the compliments are passed out by the administration and the medical staff after the hospital has successfully passed inspection for accreditation, *Dr. W. D. James* pointed out recently when he addressed the Wisconsin Medical Record librarians at their annual session in Milwaukee.

Having been a registrar of a 1000-bed station hospital for 18 months during World War II, Doctor James expressed his personal regard for record keeping.

He stressed the value of the medical record librarian to the practicing physician with the following points:

- When a patient is discharged from the hospital, his record must be checked to make certain that it is complete.
- Diagnoses must be carefully checked to determine proper nomenclature so that correct coding can be made.
- Records, their completeness and accuracy, are especially important when readmitting patients.
- Physicians must have ready access to pathologic tissue reports and results of laboratory tests.
- Accurate patient records are vital to a patient's economic well-being and his estate planning.
- Details of a patient's record assist a physician when he is called upon to testify in court.
- Complete accuracy in records from the emergency room is especially important.
- A constant check must be maintained to keep patient charts complete and current.
- Classification of records according to diagnosis is another valuable service.
- Medical writers on the hospital staff often obtain their source material from the medical record library.
- Many record librarians have the responsibility of the cancer registry.
- Another service is in the checking of records to see which ones must be analyzed by the medical staff utilization review committee.

As president of the State Medical Society Doctor James is available for speaking engagements throughout the state. Arrangements can be made by contacting the Speakers Bureau, State Medical Society, Box 1109, Madison 53701, or phone (608) 257–6781. All reservations must be made 30 days in advance.

SECTION

OPHTHALMOLOGY

NOVEMBER 1968

EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

PHOTOCOAGULATION OF THE RETINOPATHIES

By FRANK L. MYERS, M.D., Madison

Coagulation of the retina with an intense focused beam of light is certainly not a new therapeutic tool. It was conceived by the German ophthalmologist, Meyer–Swickerath, shortly after World War II. With the advent of the xenon bulb the instrument attained its present state.

The Zeiss instrument consists of a large housing for the light bulb and electrical connections and a long projecting trunk containing the focusing lenses and diaphragms. On the end of the trunk is an instrument like a direct ophthalmoscope without lenses. The retina is viewed in the same fashion as with a direct ophthalmoscope. The full light of the machine is on at all times but a filter screens out most of the light for viewing purposes. Pressing a button on the side of the ophthalmoscope moves the filter out of the way allowing the full strength of the light to pass through the pupil.

The light is white light, that is, polychromatic, and is incoherent. This is in contradistinction to laser light which is monochromatic and coherent. The light energy from the photocoagulator is absorbed by the pigment in the pigment epithelium and choroid as well as by hemoglobin and is converted into heat, causing a burn of the retina and choroid. No effect can be obtained on retina that is detached, unless colored subretinal exudate underlies the retina. This is because the distance from the pigment where the heat is generated is too great and the energy is all dissipated.

There are four main indications for photocoagulation. Anomalies of the retinal vasculature are most amenable to this form of treatment. Its use in proliferative diabetic retinopathy has nearly progressed beyond the experimental stage and appears promising in properly selected cases. Its use in retinal detachments is limited to occasional prophylactic treatment of tears without detachment, in selected cases after surgery to avoid reoperation, and in retinoschesis. Macular lesions such as central serous retinopathy of long-standing or histoplasmosis are treatable. However, a leak of fluorescein must be demonstrated on fluorescein angiography and the leak must be at least a half disc diameter or more away from the fovea.

Intravenous fluorescein studies can be very helpful in determining the suitability of cases for photocoagulation, especially macular lesions. While

continued on page 64

Presented at the fall meeting of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, Bailey's Harbor, Sept. 21, 1968.

Doctor Myers is supported by special fellowship NB 1882 from the National Institute of Neurological Diseases and Blindness.

VOLUNTARY DUES ASSESSMENT

The Executive Committee would like to remind all Ophthalmologists that voluntary dues for the year 1968 are still being received. At this date, 42 members of the Section have sent in their checks, compared to 75 at this date last year.

The regular membership contribution is $100. Educational membership contribution, for physicians who derive no part of their income from private practice, has been set at $50.

Checks are payable to: Section on Ophthalmology. Mail to: State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

WISCONSIN–UPPER MICHIGAN O–O

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology met at Bailey's Harbor Sept. 20–22. Dr. Robert Randolph of Manitowoc conducted the meeting that was attended by 34 members.

Dr. Frank Myers from the University of Wisconsin spoke on "Photocoagulation in Retinopathies." Dr. Richard Dortzbach from the University of Wisconsin spoke on "Principles of Surgery of the Eyelids."

Dr. James Brandenburg from the University of Wisconsin spoke on the "Current Approach to Carcinoma of the Larynx" and "Evaluation and Management of Laryngeal Injury."

Officers for the coming year were chosen: Dr. Frank Cerny, Fond du Lac, president; Dr. John Berger, Madison, president-elect; Dr. George L. McCormick, Waukesha, secretary-treasurer; censors, Dr. Robert D. De Cock, Appleton, and Dr. D. P. Hornbogen, Marquette, Mich.

Physicians interested in joining this organization should contact Dr. George L. McCormick, 102 E. Main St., Waukesha, Wis. 53186.

UW Geneticists Create Artificial Ribosome

Ribosomes that perform just like the ones in living cells have been created artificially for the first time.

Two University of Wisconsin geneticists have produced active hybrid ribosomes by combining separated parts of ribosomes taken from different kinds of bacteria, and in doing so they may have opened a new road toward better understanding of diseases such as cancer.

Earlier this year, these same researchers—Masayasu Nomura and Peter Traub—accomplished a breakthrough when they reassembled an active ribosome after breaking it down into its molecular components—that is, RNA and protein macromolecules. In that experiment, only ribosomes from one kind of bacteria were involved.

When they reported their first ribosome reassembly, Nomura and Traub noted that macromolecules from yeast or rat liver ribosomes would not work in place of similar macromolecules from bacterial ribosomes. Because of this finding, production of "artificial" ribosomes seemed highly unlikely.

Now, in an extension of their original work, Nomura and Traub have found that similar macromolecules from ribosomes of distantly related bacteria are often interchangeable. This was demonstrated when several different artificial ribosomes were produced simply by blending ribosome parts from different species of bacteria.

"We thought we had about a 50–50 chance when we started this experiment," Nomura confessed. "There are very many chemical differences in the ribosomes of these different bacteria, but we also noticed several similarities."

Apparently, the similarities outweighed the differences, and hybrid ribosomes were created.

Nomura and Traub were assisted by Helga Bechmann. The U.S. Public Health Service and the National Science Foundation supported their work.

Nomura is a full professor of genetics at the University of Wisconsin and Traub was a postdoctoral fellow, but recently returned to his native Germany.

With the Nomura–Traub technique for reconstituting natural and artificial ribosomes, researchers now can test directly how different parts of ribosomes are involved in the cell's protein-making process. In addition, a long-range result of this research may be a more complete understanding of diseases caused by unregulated growth of cells. For example, a deeper knowledge of protein production and its regulation by normal cells could possibly be carried over to a study of unregulated protein production by ribosomes of cancer cells.—JOHN WOLF, UIR Science Writing Division

OPHTHALMOLOGY *continued*

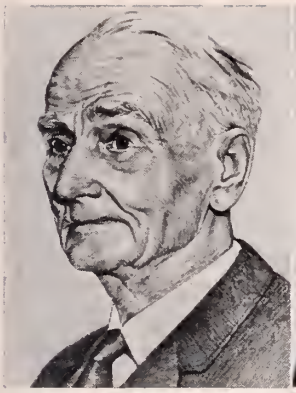
documentation with photographs is necessary in research, it is not needed for ordinary clinical purposes. With the use of cobalt blue filter on a slit lamp or a No. 47 A Wratten filter on a binocular indirect ophthalmoscope, this important new procedure can be used by any ophthalmologist. Five cubic centimeters of a 10% fluorescein solution is injected at moderate speed in an antecubital vein. Although allergic reactions are extremely rare, it probably should not be used on anyone with an extensive allergic history. An occasional person will experience a wave of nausea 30 seconds or so after the injection, but this usually passes away after a few deep breaths.

After completion of the injection with the patient sitting in the examining chair the slit lamp is moved into place. It is necessary to use the Hruby lens along with the blue light. A Goldmann 3 mirror contact lens is better, but we prefer the Worst flat contact lens. One looks for the appearance of a gradually enlarging spot or area of green fluorescence. If this is seen it means there is a break in the pigment epithelium or Bruchs membrane allowing fluorescein from the choroidal circulation to penetrate into the subpigment epithelial or subretinal space. If this area is far enough from the fovea, it can be photocoagulated in an attempt to seal it off. A similar fluorescein technique is used to study diabetics to determine areas of fluorescein leaks from new vessels. If these new vessels are flat on the retina they can be photocoagulated.

Our usual procedure for photocoagulation is to admit the patient to the hospital the night before the treatment, but in the less extensive cases it can be done as an outpatient. The patient is given a hypo about 45 minutes before the procedure and the pupil dilated in the usual fashion. A retrobulbar injection of 4 ml of 2% lidocaine (Xylocaine) with hyaluronidase (Wydase) is then given. If good immobilization of the eye is not obtained, an additional 2 ml of Xylocaine is given. Although photocoagulation in itself is not painful, relatively good immobilization of the eye is important. We have on occasion done the procedure under topical anesthesia but it is difficult, and certainly it would not be tried for treatment of macular lesions. During the procedure the cornea is copiously irrigated with normal saline to prevent drying and to help cool the eye. Postoperatively one drop of ½% prednisolone phosphate sodium (Hydeltrasol) is given in the eye and the eye patched. If treatment is extensive ½% atropine is given once and Hydeltrasol continued four times a day for several days. The eye can be unpatched after the retrobulbar anesthesia wears off in several hours. The patient is discharged home the following morning after examination.

With the passage of time and increasing experience it is becoming evident that photocoagulation is an important modality in the treatment of the retinopathies.

OBITUARIES



Paul H. Fowler, MD

Harry E. Kasten, MD

Dr. Paul H. Fowler, 87, Plain, died Aug. 28, 1968, in a Madison hospital after a brief illness. He had practiced medicine for 62 years, mostly in Plain.

Doctor Fowler was born on an Indian reservation in Santee, Neb., where his father was a missionary. He graduated from the University of Minnesota Medical School in 1903 and interned at the Mayo Clinic, Rochester, Minn. In 1905 he began his practice in Plain.

He enlisted in the armed forces during World War I and served in France as a captain in the medical corps. While there he participated in the Meuse–Argonne offensive. After the Armistice he took postgraduate work in internal medicine at the University of Aix en Provence, France. Upon returning to the United States he was active as a major in the Army Reserves. In 1958 he was given a lifetime membership in the Plain American Legion post.

In 1954, the State Medical Society of Wisconsin honored Doctor Fowler for his 50 years of medical practice. Doctor Fowler retired from active practice in 1964 and had resided with a daughter in Middleton. He was a member of the Sauk County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Survivors include one son, Wallace, Elmira, N.Y.; and four daughters, Mrs. Viola Sly, Madison; Mrs. Edwin Dodge, Middleton; Mrs. James Van Lanen, Peoria, Ill.; and Mrs. Claude Kirkpatrick, Sepulveda, Calif. Mrs. Fowler preceded him in death in 1961.

Dr. Vito Guardalabene, 59, Milwaukee, ditd Sept. 3, 1968, in Milwaukee.

Doctor Guardalabene graduated from the University of Minnesota School of Medicine in 1935. Before entering service in 1942, he was chief medical officer of the civilian conservation corps in the middle western states. After serving in the United States Army Medical Corps for four years, he opened his offices in West Allis. He was a member of the Wisconsin Academy of General Practice and on the staff of St. Michael's and Deaconess Hospitals, Milwaukee.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Katherine; and three children, Yvonne and Adrienne, Milwaukee, and Mrs. Carla Widener, Barcelona, Spain.

Dr. Henry R. Rettig, 70, Milwaukee, died Sept. 14, 1968, in Milwaukee.

Doctor Rettig graduated from the Marquette University School of Medicine in 1925. His internship was taken at Columbia Hospital, Milwaukee, and residency at Woman's Hospital, Detroit, Mich. Doctor Rettig was on the medical staffs of St. Joseph and St. Anthony hospitals, Milwaukee.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving is his widow, Margaret.

Dr. Elmer E. Bertolaet, 64, West Allis, died Sept. 18, 1968, in Ann Arbor, Mich.

Doctor Bertolaet graduated from the University of Wisconsin Medical School in 1931 and interned at Milwaukee Hospital. He took postgraduate work in public health at the University of Minnesota. Doctor Bertolaet practiced in Palmyra until 1947 when he became connected with the State Board of Health in Elkhorn. In 1953, he accepted the directorship of the City Health Department of Kenosha and retired in 1967.

He was a member of the American Public Health Association, Middle States Public Health Association, and Wisconsin Public Health Association.

Surviving is his widow, Edna, and a son, Dr. Fred Bertolaet, Ann Arbor, Mich.

Dr. Harry E. Kasten, 79, prominent Beloit physician and surgeon, died Sept. 28, 1968, in Madison following a short illness.

A past president of the State Medical Society (1957–1958), Doctor Kasten was one of the organizers of the voluntary prepaid health-care insurance program now known as Wisconsin Physicians Service–Blue Shield. He also was a founder of the Museum of Medical Progress at Prairie du Chien.

Born in Wisconsin in 1888, he attended rural schools and was graduated from Juneau High School. After attending Milwaukee State Normal School he spent 10 years teaching grade school in Oak Grove and Burnette and was a high school principal at Friendship for one year. He left teaching to attend the University of Wisconsin where he became an

instructor in Anatomy. He received his M.D. degree in 1921 from Rush Medical School and began his practice in Beloit a year later.

He was always interested in young people and served his community in many ways. He was a fine musician in his younger days and was active in city government and recreational programs. He remained an avid photographer throughout life.

In his medical practice he specialized in urology and dermatology. Doctor Kasten was particularly interested in medical organization and belonged to several national medical groups as well as the Rock County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Doctor Kasten's close association with the State Medical Society was exemplified in 1957 when, as the 102nd president, he presented a tree for the Society grounds.

Doctor Kasten was president of the North Central Medical Conference in 1954. From 1948–1957, he served as State Society councilor of the Third District. He served on the executive committee and as a member of the Commission on Medical Care Plans, the governing body for WPS–Blue Shield insurance, from 1947–1959 and has been honored for his work in consolidating the various statewide medical plans for WPS.

He held offices in practically every group to which he belonged, local, state and national. He was a member of the World Medical Association and a life member and vice-president in 1955 of the American Medical Association of Vienna where he had done postgraduate work earlier in his career.

Doctor Kasten was elected to *Who's Who in America* in December 1958 and was also included in other specialty Who's Who publications.

Dr. H. E. Kasten

To an uncommon degree, Dr. Harry E. Kasten was a "giver" for the betterment of his fellow man. His death removes from the Beloit scene both an exceptional talent and a generous spirit. Both are distinct assets; the latter most rare.

Dr. Kasten gave of himself as a teacher, a healer, an advocate of health, a booster of youth, a provider of material aid, a builder of his adopted community, and a leader in public affairs. His "gift" to others even extended to entertainment; he was an accomplished musician.

Not many make so total a commitment in so many ways, but Beloit is fortunate in having had men like Dr. Kasten, who have done (and do) more than "their share" to make life and living better for all.

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BELOIT DAILY NEWS—Oct. 1, 1968

Surviving is his widow, Irene, and several nieces and nephews.

Dr. John P. Walker, 51, former Wisconsin physician, died Sept. 28, 1968, in Lincoln, Ill.

Doctor Walker graduated from Marquette University School of Medicine in 1944 and interned at Milwaukee County General Hospital. He had practiced in Mondovi, Rio, and Waupun before accepting a position at the Lincoln State School, Lincoln, Ill. Doctor Walker served in World War II and was a captain in the Air Force during the Korean conflict.

Surviving are his widow, Constance, two sons, John, Lincoln; Paul, Mondovi; and two daughters, Mary and Patricia, Lincoln, Ill.

FILMS: MANAGEMENT OF SPECIFIC CANCERS

Five discussions of the current concepts in the management of specific cancers are now available on 16-millimeter films for viewing by physicians.

The discussions were taken from the 1967 and 1968 meetings of the American Radium Society (ARS) and produced and distributed as a joint effort of the ARS and American College of Radiology (ACR) Committees on Audio–Visual Media. Production of the films from videotape recordings is supported by a grant from the Cancer Control Branch of the U. S. Public Health Service.

The two sessions from the 1967 ARS meeting in Toronto feature the entire presentations to the meeting of a discussion of management of cancer of the cervix and a second panel dealing with testicular tumors. The panel on the cervix runs approximately 90 minutes and the one on testicular tumors occupies about an hour.

The 1968 presentations were prepared specifically for filming and consist of 20-minute versions of the full panel as presented to the ARS meeting.

The discussions feature current approaches to cancer of the prostate, the esophagus and solid tumors in children.

Single prints of the longer 1967 films are available for loan from the American Medical Association film library (535 North Dearborn Street, Chicago).

The 1968 films can be borrowed from the AMA and can be purchased from the College for $55 per print.

* * *

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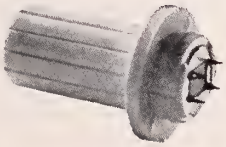

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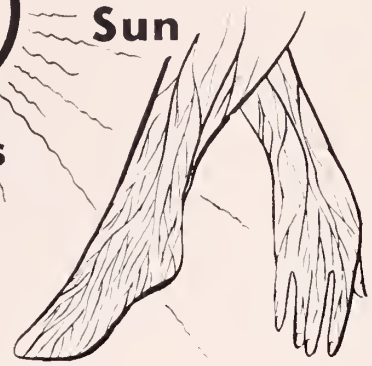

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REFERENCES:

1. Goodgold, J., Use of Nicotinic Acid-Glycine Mixture in Treatment of Peripheral Vascular Disease, Clinical Medicine 7:12 (1960).
2. Gustafson, Jr. et al. Use of Glycine in the Treatment of Peripheral Vascular Disease, Surgery 25:539 (1949).

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF OCTOBER 15, 1968

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Avestruz, Nerissa L., Spring Valley 54767
Best, John D., 601 Reed Ave., Manitowoc 54220
Bourne, Charles W., MC—USS Repose % Fleet P. O., San Francisco, Calif. 96601
Capati, Nazario R., Neillsville Clinic, Neillsville 54456
Christian, James A., 5433 West National Ave., Milwaukee 53214
Cicero, James J., 539 North 8th St., River Falls 54022
Cooper, George N., 810 N. 117th St., Wauwatosa 53226
Engel, Charles H., 134 N. Leonard St., West Salem 54669
Ferrazzano, G. P., City Hall, Room 106, Racine 53401
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Johnson, Paul S., 425 Main St., Racine 53403
Kamper, David G., 324 E. Wisconsin Ave., Milwaukee 53202
Kind, Allan C., University of Wisconsin Medical School, Madison 53706
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Link, Charles E., 212 South 11th St., La Crosse 54601
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Locher, Roland A., 1836 South Ave., La Crosse 54601
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Melby, Neal Arthur, New Richmond Clinic, New Richmond 54017
Rodgers, Richard E., 8700 West Wisconsin Ave., Milwaukee 53226
Russell, Thomas J., 111 East Wisconsin Ave., Milwaukee 53202
Stupek, Warren S., 1625 Garfield St., Fennimore 53809
Tsuchiya, Goro, 312-7th St., Racine 53403
Tucker, Erskine R., 2900 West Oklahoma Ave., Milwaukee 53215
Turner, Arthur J., 208 E. Wisconsin Ave., Milwaukee 53202
Walker, Thomas F., 3811 South Miner St., Greenfield 53221
Wrigley, John B., River Falls Medical Clinic, River Falls 54022
Youker, James E., 8700 West Wisconsin Ave., Milwaukee 53226

CHANGES OF ADDRESS

Albright, John G., 6002 Greentree Rd., Madison 53711
Allen, John R., 1 West Wilson St., Madison 53702
Beaumier, John H., Marshfield, to 2602 Olive St., Grand Forks, North Dakota 58201
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Clarke, Gary S., Chetek, to 8213 Washburn Ave., South, Bloomington, Minn. 55420
Cogan, Leo J., 2500 North Mayfair Rd., Milwaukee 53222
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Gager, Walter E., Shorewood, to 14935 Franklin Dr., Brookfield 53005
Gale, Henry H., 6745 West Wells St., Milwaukee 53213
Ganser, Leonard J., 1 West Wilson St., Room 344, Madison 53702
Garman, James E., Milwaukee, to 2004 Rockwood Blvd., Spokane, Wash. 99205
Goerke, Robert F., Wood, to 811 East Wisconsin Ave., Milwaukee 53202
Gordon, Robert P., Jr., Elgin, Ill., to 109 Harbour Terr., Elmhurst, Ill. 60126
Hamm, Harold J., 425 East Wisconsin Ave., Milwaukee 53202
Headlee, C. Raymond, Wauwatosa, to 12505 Gremoor Rd., Elm Grove 53122
High, Anne L., 4461 North Lake Dr., Milwaukee 53211
Hirschler, Charles W., 4410 Boulder Terr., Madison 53711
Huewe, Douglas A., Wauwatosa, to 1870 Ludington Ave., Milwaukee 53226
Hull, Harmon H., Waupun, to 558 San Antonio St., Santa Fe, New Mexico 87501
Jorris, Edwin H., 1 West Wilson St., Madison 53702
Jurss, Charles D., Milwaukee, to 329 Sudduth Circle, N.E., Fort Walton Beach, Fla. 32548
Klein, Alfred J., 1502 South Hastings Way, Eau Claire 54701
Klumb, Milton G., 6533 West Center St., Milwaukee 53210
Kinsey, Jack L., Spring Valley, Ill., to 2410 Alhatrani Dr., San Diego, Calif. 92101
Maas, David A., 816-17th Ave., North, Boseman, Mont. 59715
Malloy, Philip J., Wauwatosa, to 6001 West Center St., Milwaukee 53210
Martens, Jacob H., 414 Kent St., Wausau 54401
Rabin, Allen, 2550 North Sherman Blvd., Milwaukee 53210
Rusch, Kenneth H., Department of Public Welfare, Division of Mental Hygiene, 1 West Wilson, Room 344, Madison 53702
Sauter, Kendall E., 2500 North Mayfair Rd., Room 607, Milwaukee 53226
Shapiro, Herman L., 117 West Blackhawk Ave., Prairie du Chien 53821
Silvis, Stephen E., Marshfield, to V. A. Hospital, Minneapolis, Minn. 55417
Spicuzza, Salvatore, San Antonio, Tex., to 4611 North Larkin St., Milwaukee 53211
Varga, Laszlo, Milwaukee, to 1220 Dewey Ave., Wauwatosa 53213

continued on page 73

SOCIETY RECORDS *continued*

REMOVED FROM MEMBERSHIP

Bolman, William M., Dane County, removed per County Secretary

Briggs, Russell C., Dane County, transferred to Maine

Bukosky, Richard J., Milwaukee County, transferred to New Jersey

Connors, Dean M., Dane County, removed per County Secretary

Curtis, John K., Dane County, removed per County Secretary

Golbert, Thomas M., Milwaukee County, transferred to Colorado

Greblo, Zorislav, Dane County, removed per County Secretary

Herhahn, Frank T., Dane County, transferred to Colorado

Lemann, Jacob, Jr., Milwaukee County, transferred to Massachusetts

Mueller, Mark N., Dane County, removed per County Secretary

DEATHS

Guardalabene, Vito, Milwaukee County, Sept. 3, 1968

Rettig, E. Henry, Milwaukee County, Sept. 14, 1968

Bertolaet, Elmer E., non-member, Sept. 18, 1968

Kasten, Harry E., Rock County, Sept. 28, 1968

Walker, John P., non-member, Sept. 28, 1968

Dr. Khorana, University of Wisconsin Scientist, Awarded Nobel Prize

H. Gobind Khorana, PhD, 46, whose studies have been supported by the Life Insurance Medical Research Fund since 1956, has been named one of three recipients of the 1968 Nobel prize in Physiology or Medicine.

Dr. Khorana, professor and group leader of the Institute of Enzyme Research at the University of Wisconsin (Madison), was awarded the prize for his work in helping to explain the genetic code through the arrangement of amino and nucleic acids that determine a cell's function.

Receiving the joint award with Dr. Khorana were Robert W. Holley, PhD, 46, a permanent resident fellow of the Salk Institute, La Jolla, Calif.; and Marshall W. Nirenberg, PhD, 41, head of the section for biochemical genetics at the National Institutes of Health, Bethesda, Md.

They will share a cash award of approximately $70,000 and also receive gold medals and diplomas, to be presented in Stockholm on Dec. 10, the anniversary of Dr. Alfred Nobel's death.

Dr. Khorana, who this year was awarded a $49,500 grant by the fund for research on chemical and enzymatic studies of polynucleotides, is the fifth Nobel prize winner to have received support from the Fund.

Dr. Khorana, who was born in Rapuir, India, was educated in India and England.

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THREE-MAN GROUP in Northwest Wisconsin Resort, State Conservation, and Retirement Area need two more physicians adequately to serve their practice. Facilities offered are three-room physician suites, x-ray and lab under AMT technician, RN only nursing personnel. New accredited 32-bed hospital and 46-bed nursing home. Deer and duck hunting, fishing within five minutes of town. Internist most needed; generalists welcomed. Will meet any reasonable salary request. Partnership after one year. Box No. 369, Spooner, Wis. 8tfn

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FOR RENT: Milwaukee, South Side, new 6-room air-conditioned office suite with dark room, near 2 large hospitals. Douglas W. Bailey, MD, Deceased, 2722 W. Oklahoma Ave., Milwaukee, Wis. 53215. g9-11

WANTED: Well-trained General Practitioner or Internist to associate with physician in town of 5,000 in east central Wisconsin. Excellent clinic and hospital facilities. Attractive salary with possibility of eventual partnership. Contact Dept. 127 in care of the Journal. 4tfn

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NINETEEN-MAN Wisconsin group located in college community of 40,000 with excellent hospital facilities is seeking additional associates in the following areas:

1. Internal Medicine
2. Urology
3. General Practice
4. Pediatrics

For further information, please contact D. R. Griffith, MD, Midelfort Clinic, Eau Claire, Wis. 54701 10-12

WANTED: GENERAL PRACTITIONER or General Surgeon willing to do general work as associate with 45-year-old General Practitioner in north central Wisconsin, town of 10,000. Full hospital privilege is available. Contact Dept. 231 in care of the Journal. 9tfn

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DODGEVILLE, WISCONSIN—Iowa County—Population 3,000. GP clinic with large medical and surgical practice desires general practitioner or physician willing to do general practice. Located on highways 18 and 151; Northwestern Railroad, City Airport at Dodgeville. Three State Parks in county. No predominant nationality. Dodgeville is the county seat and main occupation is farming. Industrial development now underway, new industry started with others soon to follow. Most denominations of churches. One parochial grade, new public grade and new high school. Two hospitals—90 bed Catholic and 40-bed municipal. Ambulance and nurses available. Country Club has golf course and trap shooting. Excellent hunting and fishing within ten-mile radius. One semi-retired doctor in city in addition to three doctors in clinic at present. The Dodgeville Clinic would like to have another doctor associate with it. Modern clinic. Salary open to begin with, opportunity for full partnership in reasonable time. Contact W. P. Hamilton, MD, N. G. Rasmussen, MD or David R. Downs, MD, Dodgeville Clinic, 109 W. Fountain St., Dodgeville, Wis., for further details. 10tfn

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ASSOCIATE leading to partnership by General Practitioner-Surgeon. Southeastern Wisconsin. College community 70,000 to 80,000. Community contains 2 open hospitals. Located on Lake Michigan midway between Chicago and Milwaukee. New clinic building. Salary the first year with partnership the second year. Please submit letter containing biographical sketch including previous training. Either general practitioner or internist. Write Dept. 272 in care of the Journal. 8tfn

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WANTED: Young General Practitioner, service completed, to join 3-man, all AAGP group. Fully equipped clinic across street from fine open staff hospital with good specialty coverage. Starting salary open, ample postgraduate study, vacation time. Shared coverage. Friendly community of 7000 with fast growing industrial and tourist interest. Superb educational and recreational facilities. Contact Dept. 268 in care of the Journal. 7tfn

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YOUNG GENERAL PRACTITIONER to join two general practitioners and one surgeon. Ages 30 to 37. Excellent professional and financial opportunity. New office building. City of 70,000 midway between Chicago and Milwaukee, with private college and new University of Wisconsin campus. Contact Dept. 288 in care of the Journal. 5tfn

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WANTED: GENERAL SURGEON, military service obligation fulfilled, to associate with four (4) young (mid-30s) general practitioners in active general practice of medicine and surgery, open 100-bed hospital, town of 10,000, salary open. Contact J. E. McKenna, MD, T. C. Fox, MD, D. V. Blink, MD, or W. A. Holm, MD, General Clinic, Antigo, Wis. 9-3

GENERAL PRACTITIONER—Student Health Service, Wisconsin State University—Oshkosh, located in a community of approximately 50,000 population in the Fox Valley area, wishes to add an additional doctor to the staff of four in the Student Health Service for a student body of approximately 12,500 students in 1969-70. Contact Sherman E. Gunderson, Vice President Program Development and Staffing, Wisconsin State University—Oshkosh. 11tfn

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FOR SALE: Fisher portable ultrasonic generator and Beck-Lee direct writing electrocardiograph. Less than eight years old. Lou R. Schmidt, MD, 403 Rivoli Bldg., La Crosse, Wis. 11-12

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 67, No. 12 DECEMBER 1968

SCIENTIFIC ARTICLES

Results of Radiation Therapy in Cancer of the Larynx; Based Upon Clinical Staging by the International TNM System, by Jacob H. Martens, M.D., Maxine E. Bennett, M.D., and Halvor Vermund, M.D., Madison ---- 585

Flurandrenolone Tape; A New Therapeutic Measure in Dermatology, by Faustino Gomez, M.D. and William F. Schorr, M.D., Marshfield ---- 596

Use of Dietary Fluorides, by Joseph M. Doherty, D.D.S., M.P.H., Madison ---- 599

Therapeutic Dilemmas: Systemic Lupus Erythematosus (No. 14 of a Series), by Harry Beckman, M.D., Milwaukee ---- 603

SPECIAL FEATURES

Annual Photography Contest: 1969 Annual Meeting ---- 11

Official Call for Scientific Exhibits: 1969 Annual Meeting ---- 12

Hepatocarcinoma Associated with Biliary Cirrhosis (abstract) ---- 595

Femoral Head Prosthesis for Hypertrophic Arthritis of the Hip (abstract) ---- 602

Minutes of Council Meeting: Mackinac Island, Mich., July 19, 1968 ---- 612

Minutes of Joint Meeting: Council and Commission on Medical Care Plans, Mackinac Island, Mich., July 20, 1968 ---- 614

Minutes of Council Meeting: Madison, October 19–20, 1968 ---- 615

Medicaid Report No. 2: How to File Claims for Persons Eligible for Railroad Medicare and the Wisconsin Medical Assistance Program (Medicaid) ---- 619

Index to Volume 67, January–December 1968 64

EDITORIALS

President's Page: Continuing Education—A Must, by William D. James, M.D., Oconomowoc ---- 609

Blue Foundations ---- 610

REGULAR FEATURES

Publication Information ---- 6

Medical Meetings ---- 7

Letters ---- 611

Physician News ---- 23

County Societies ---- 30

Specialty Societies ---- 30

Section on Ophthalmology ---- 31

Paramedical/Ancillary ---- 32

Medical Green Sheet ---- 33

Wisconsin Physicians Service ---- 58

Bookshelf ---- 60

Physicians Exchange ---- 61

Index to Advertisers ---- 65

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Journal
Established 1903

Annual Subscription ---- $10.00
Single Copy ---- 1.50
Previous Years' ---- 3.00
January Blue Book ---- 5.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago, Illinois 60610; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin 54481.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison, Wisconsin 53701.

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Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual.* Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1969 WISCONSIN

Jan. 12: Annual meeting, Central Wisconsin Chapter of National Multiple Sclerosis Society, at State Medical Society of Wisconsin, Madison.

Jan. 16: "In-depth" teaching program—I'm Too Tired, Dear, University of Wisconsin Medical School and State Medical Society of Wisconsin, Madison.

Jan. 27: Wisconsin Council of Safety Seminar, Park Motor Inn, Madison.

Feb. 19: "In-depth" teaching program—Respiratory Therapy, University of Wisconsin Medical School and State Medical Society of Wisconsin, Madison.

Mar. 6: Senior Medical School Day of Senior Medical School Week, State Medical Society of Wisconsin, Madison.

Mar. 13: "In-depth" teaching program—Female Hormones at Age Fifty, University of Wisconsin Medical School and State Medical Society of Wisconsin, Madison.

Mar. 27–29: Conference on Primary Pediatrics and the Processes of Child Health Care, Department of Pediatrics, University of Wisconsin Medical Center and Department of Postgraduate Medicine, University of Wisconsin Extension, at Wisconsin Center, Madison.

May 1: Jackson Clinic–Marquette School of Medicine postgraduate teaching program, Madison.

May 7: Projected Clinics, Wisconsin State Dental Society.

May 12–15: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

Spring: Conference on Pesticides and Insecticides, Committee on Occupational Health of State Medical Society of Wisconsin.

Spring: Town–Gown Symposium, State Medical Society of Wisconsin.

1969 NEIGHBORING STATES

Apr. 11–13: Annual meeting, National Association of Blue Shield Plans, Chicago, Ill.

April 20–25: 50th Annual Session, American College of Physicians, Conrad Hilton Hotel, Chicago, Ill.

Apr. 30–May 4: M.A.C. VI-Midwest Anesthesiology Conference, Illinois Society of Anesthesiologists, Palmer House, Chicago.

June 10–13: Annual convention, Catholic Hospital Association, Minneapolis, Minn.

Oct. 25–26: North Central Medical Conference, St. Paul Hilton, St. Paul, Minn.

1969 OTHERS

Jan.: AHA Council on Clinical Cardiology—"Cardiopulmonary Physiology," San Francisco, Calif.

Jan. 5–8: Joint Conference on Medical Conventions, MEA–PCMA, Atlanta, Ga.

Jan. 12–17: Annual meeting, Society for Cryosurgery, Hilton Piaza, Miami Beach, Fla.

Jan. 22–26: ACP postgraduate course—"Psychiatry for the Internist, Albert Einstein College of Medicine, Bronx, N.Y.

Jan. 27–29: Annual session, International Medical Assembly of Southwest Texas, San Antonio, Tex.

Feb.: ACP postgraduate course—Gastroenterology, Louisiana State University, New Orleans.

Feb. 3–5: Sectional meeting, American College of Surgeons, featuring general surgery, urology, orthopedics, Fontanelle Hotel, Omaha, Neb.

Feb. 8–13: Annual Congress and Teaching Seminar, International Academy of Proctology, Hollywood Beach Hotel and Country Club, Hollywood, Fla.

Feb. 17–21: ACP postgraduate course—The Patient and His Family, University of Cincinnati College of Medicine, Cincinnati, Ohio.

Feb. 21–22: Postgraduate continuation course in Gastroenterology, Institute of Gastroenterology, Good Samaritan Hospital, and VA Hospital, Del Webb TowneHouse, Phoenix, Ariz.

Feb. 24–26: Sectional meeting, American College of Surgeons, featuring gynecology-obstetrics, neurosurgery, general surgery, and symposium on trauma, Brown Hotel, Louisville, Ky.

Mar. 10–12: Joint meeting for doctors and nurses, American College of Surgeons, featuring general surgery and eight surgical specialties, Sheraton–Boston Hotel, Boston, Mass.

Mar. 10–13: Annual meeting, New Orleans Graduate Medical Assembly, The Roosevelt Hotel, New Orleans, La.

Mar. 24–28: ACP postgraduate course—Modern Pathology for the Internist, University of Pittsburgh, Pittsburgh, Pa.

Mar. 31–Apr. 2: Psychiatry and the Internist (20th symposium), Hahnemann Medical College and Hospital, Philadelphia, Pa.

Apr.: AHA Council on Clinical Cardiology—"Clinical Electrocardiography and Vectorcardiography," Augusta Ga.

Apr. 18: Annual symposium on Infectious Diseases, American Academy of General Practice, Battenfield Auditorium, Kansas City, Kan.

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

Apr. 21–25: 50th annual session, American College of Physicians, Chicago, Ill.

May 8–10: National Conference on Breast Cancer, American Cancer Society, Shoreham Hotel, Washington, D.C.

May 12–16: ACP postgraduate course—Internal Medicine, University of Pennsylvania School of Medicine (Pennsylvania Hospital), Philadelphia, Pa.

June: AHA Council on Clinical Cardiology, title and location to be announced.

June 9–13: ACP postgraduate course—Neurology for the Internist, Bowman Gray School of Medicine, Winston-Salem, N.C.

June 16–19: ACP postgraduate course—Auscultation of the Heart, University of Oregon Medical School, Portland, Ore.

June 16–20: ACP postgraduate course—Hematology, University of Rochester School of Medicine, Rochester, N.Y.

July 7–11: Postgraduate Course—Clinical Electrocardiographic Interpretation, Hahnemann Medical College and Hospital, Philadelphia, Pa.

July 14–18: Postgraduate course—Interpretation of Cardiac Arrhythmias, Hahnemann Medical College and Hospital, Philadelphia, Pa.

Aug. 11–17: Postgraduate course—Space Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pa.

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MEDICAL MEETINGS *continued*

Aug. 24–29: Eighth International Congress of Gerontology, Sheraton Park and Shoreham hotels, Washington, D.C. and Baltimore, Md.

Sept. 29–30, Oct. 1: AHA Council on Clinical Cardiology —"Coronary Disease," Boston, Mass.

Oct. 6–10: Meeting, American College of Surgeons, San Francisco, Calif.

Oct. 13–16: Interstate Postgraduate Medical Assembly, Cleveland, Ohio.

Oct. 14–22: Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Oct. 30–31: Blue Shield annual program conference, National Association of Blue Shield Plans, San Francisco Hilton, San Francisco, Calif.

Nov. 10–11: AHA Council on Arteriosclerosis, 23rd annual meeting, Dallas, Tex.

Nov. 12–15: AHA 42nd scientific sessions, Dallas, Tex.

Nov. 16–17: AHA annual assembly meeting, Dallas, Tex.

Dec. 8–12: Postgraduate course—Emergency Medical Care (21st symposium), Hahnemann Medical College and Hospital, Philadelphia, Pa.

Winter: AHA Council on Clinical Cardiology—"Clinical Use of Cardiovascular Drugs," La Jolla, Calif.

1969 AMA

July 13–19: Annual meeting, American Medical Association, New York City.

Nov. 30–Dec. 3: Clinical Session, Denver, Colo.

1970 WISCONSIN

May 11–14: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

1970 AMA

Apr. 10–11: Rural Health Conference, American Medical Association, Milwaukee.

June 21–25: Annual Session, Chicago, Ill.

Nov. 29–Dec. 2: Clinical Session, Boston, Mass.

1970 OTHERS

Aug. 23–28: VII International Congress of Diabetes, Buenos Aires, Argentina.

Sept. 28–Oct. 1: Annual scientific assembly, American Academy of General Practice, Civic Auditorium, San Francisco, Calif.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

"In-depth" Teaching Program, Madison

The second in a series of four "in-depth" teaching programs provided by the University of Wisconsin Medical School faculty in cooperation with the State Medical Society of Wisconsin will be held Jan. 16 on the subject "I'm Too Tired, Dear."

The morning program of patient discussions will start at 10 a.m. in Room 300 of University Hospitals. The group will move to the State Medical Society headquarters for a 12:30 luncheon, followed by an afternoon program in the Presidents Room of the Society building. Following lectures, the registrants will split into small groups for an informal one-hour discussion of problems with one or two of the faculty.

Faculty: Andrew S. Ferber, MD, director of Family Studies, Albert Einstein College of Medicine, New York; Carl A. Whitaker, MD, assisted by the resident staff, Department of Psychiatry.

Topics: It is planned to use the psychodrama as a method of Problem Presentation and Resolution of Stress . . . "Inter-personal Relationships in Marriage" . . . "Guidelines for Assisting Couples to Improve Their Relationships to Each Other."

Registration in advance ($5.00) to: CES Foundation, State Medical Society of Wisconsin, Attn: David C. Reynolds, Box 1109, Madison, Wis. 53701.

New Orleans Graduate Medical Assembly

The thirty-second annual meeting of The New Orleans Graduate Medical Assembly will be held March 10–13, 1969, headquarters at The Roosevelt Hotel.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 50 informative discussions on many topics of current medical interest, in addition to a clinicopathologic conference, medical motion pictures, roundtable luncheons, and technical exhibits. This program is acceptable for 3½ prescribed hours and 28 elective hours by the American Academy of General Practice.

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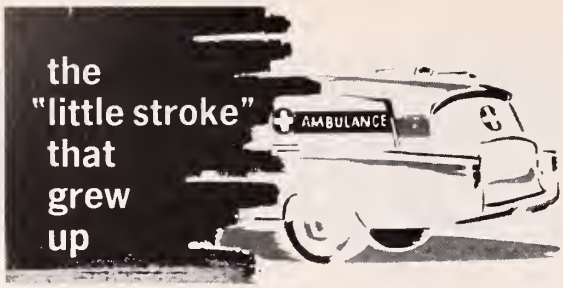
Lectures, symposia, clinicopathologic conference, round-table luncheons, medical motion pictures, technical exhibits, and entertainment for visiting wives.

(All-inclusive registration fee—$30.00)

This program is acceptable for three and one-half (3½) prescribed hours and twenty-eight (28) elective hours by the American Academy of General Practice.

For information concerning the Assembly meeting write Secretary, The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Avenue, New Orleans, Louisiana 70112.



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[1] Gale, E. T. and Thewlis, M. W., Geriatrics 8:80, 1953
[2] Personal Communication: R. C. Brunner, Pharmaceutical Div., Sunkist Growers

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MEDICAL MEETINGS *continued*

Multiple Sclerosis Society Meeting

The Central Wisconsin Chapter of the National Multiple Sclerosis Society will hold its annual meeting Jan. 12 at 2:00 p.m. at the State Medical Society headquarters in Madison (330 East Lakeside Street). Three speakers will make presentations: Dr. Cornelius L. Harper of the Department of Neurology, University of Wisconsin Medical Center, "Multiple Sclerosis—A New Perspective;" Dr. Robert Harris of the Enzyme Laboratory of the UW Medical Center and Dr. Steven Kornbuth of the Department of Neurology, UW Medical Center, "Current Research in Multiple Sclerosis."

Conference on Pediatrics at Madison

The Department of Pediatrics, University of Wisconsin Medical Center and Department of Postgraduate Medicine, University of Wisconsin Extension, will present a conference on "Primary Pediatrics and the Processes of Child Health Care" in Madison Mar. 27–29, 1969, at the Wisconsin Center.

The program is designed to provide physicians interested in child health with a better understanding of concepts such as the organization and functions of the health services system, current approaches to child care in various socio-economic settings, organization of practice to augment physician effectiveness, the professional patient relationship, interviewing techniques, methods for handling and analyzing medical data, and evaluation of the patient care process.

Guest speakers will include Drs. Richard McGraw, E. D. Harrington, Henry Shinefield, and Evan Charney.

For further information contact Thomas C. Meyer, MD, Associate Dean, University of Wisconsin Extension Division, 432 North Lake Street, Madison, Wis. 53706.

American Industrial Health Conference

The 1969 American Industrial Health Conference will be held April 21–24 in Houston, Tex., with headquarters at the Shamrock Hilton, it has been announced by the Industrial Medical Association and the American Association of Industrial Nurses.

Further information about the conference may be obtained by writing American Industrial Health Conference, 55 East Washington Street, Chicago, Ill. 60602.

CORRECTION

The fourth and final program in the series of one-day 'in-depth' teaching programs has been rescheduled for Thursday, Mar. 13, instead of Mar. 20. The program is entitled "Female Hormones at Age Fifty." Co-sponsors are the University of Wisconsin and the State Medical Society of Wisconsin.

Drs. Sarah, Milton Rosekrans Honored

Drs. Sarah and *Milton C. Rosekrans*, a husband and wife physician–surgeon team in Neillsville, were recently honored for their 39 years of professional service to the community. Both doctors have been active in community affairs and have served as chief of the medical staff at Memorial Hospital in Neillsville. Dr. Milton Rosekrans has also been city health officer for many years.

Dr. Dougherty Speaks on Weight Control

Dr. Philip J. Dougherty of Menomonee Falls discussed weight control and heart disease at one of two meetings recently held on that subject in West Bend. The programs were cosponsored by University of Wisconsin Extension, Washington County home economist, and the Wisconsin Heart Association.

Dean Kerrigan Addresses HAPC

At the quarterly meeting of the Hospital Area Planning Committee Nov. 1 in Milwaukee, *Dr. Gerald A. Kerrigan*, dean of Marquette School of Medicine, suggested that schools like Marquette should help overcome inadequacies and discrepancies of the United States' health-care system.

As reported in the MILWAUKEE JOURNAL, he said the health resources of the United States were the best in the world, but that the rising incidence of heart, lung, and kidney diseases, an infant death rate that was only eleventh lowest in the world, and an infant death rate twice as high for Negroes as for whites, all were indications of the need for a better system of using health resources. Research in improving the system may be one responsibility medical schools should undertake, Doctor Kerrigan said. He said Marquette medical school was beginning to play a larger part in community health care because Milwaukee County General Hospital, where the Marquette faculty teaches, now is open to everyone, not just the indigent.

Dr. Russo Heads Sanatorium Group

Dr. John G. Russo, superintendent and medical director of Riverview Sanatorium in Kaukauna, recently was elected president of the Wisconsin Sanatorium Superintendents' Association.

Present Film at Surgeons' Congress

Dr. Frederick J. Hofmeister, chairman of the Department of Obstetrics and Gynecology at Lutheran Hospital of Milwaukee, Inc. and associate clinical professor, Department of Obstetrics and Gynecology at Marquette School of Medicine, Inc. presented the film, "Low Cervical Cesarean Section" at the Clinic of the American College of Surgeons Clinical Congress in Atlantic City, Oct. 17. Co-authors of the film are Dr. Beverly Joan Straits, resident in Gynecology and Obstetrics, Lutheran Hospital of Milwaukee, and *Dr. William J. O'Leary, Jr.*, former resident in Gynecology and Obstetrics, Lutheran Hospital of Milwaukee. The three authors received plaques for their film contribution to the program.

Dr. Joseph Seidl Retires

A Grafton physician, *Dr. Joseph A. Seidl*, retired from practice Dec. 1. He had been associated with *Dr. K. F. Pelant* who is now the only physician serving the Grafton area of 6,000 people.

New Assistant Dean Named, Marquette

A Marquette School of Medicine physician, Dr. Albert C. Yard, has been selected to fill the post of Assistant Dean of Student Affairs for the school. His appointment completes a group of four made in recent weeks to new deanship positions created to handle special administrative duties of the medical school.

The appointment was announced Oct. 30 by *Dr. Gerald A. Kerrigan*, dean. The other deanship positions include *Dr. Harold F. Hardman* as basic science associate dean; Dr. Edward J. Lennon, clinical associate dean; and Dr. Donald Geiff, graduate associate dean.

Doctor Yard is an associate professor of pharmacology, a position he will continue to hold. He will be the administrator for a number of activities which relate specifically to medical students. Doctor Yard received his Ph.D. degree from the University of Manitoba, Canada, and joined the Marquette faculty in 1956. While working as a pharmacology instructor, he began studies for his medical degree which he received from Marquette in 1961.

Dr. Cantwell, Jr. Joins Clinic

Dr. Arthur A. Cantwell, Jr. recently joined the staff of the Cantwell–Peterson Clinic in Shawano. Doctor Cantwell is a native of Shawano and graduated from the Northwestern University Medical School in 1961. He served his internship at Cook County Hospital, Chicago, and spent two years in the Air Force during which time he served three months as flight medical officer in the School of Aviation Medicine–Aerospace in San Antonio, Tex. The past four years have been spent in surgical residency at the Santa Barbara General Hospital, California.

Dr. Klasinski Opens Practice

Dr. C. A. Klasinski, Stevens Point, recently opened his office for orthopedic surgery. Doctor Klasinski is a native of Stevens Point and graduated in 1960 from Loyola's Stritch School of Medicine. He interned in Hammond, Ind., and practiced three years in Wautoma. In 1964 he began residency

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Physicians whose names appear in italics are members of the State Medical Society.

training in surgery in Milwaukee and in 1965 started his training in orthopedic surgery at Henry Ford Hospital, Detroit, Mich. Doctor Klasinski completed his orthopedic training there as head resident in 1967 and received additional training as a fellow in plastic surgery at Henry Ford Hospital where he was also engaged in research in hand surgery. Before coming to Stevens Point, he was a member of the staff in the Division of Plastic Surgery at Henry Ford Clinics and Hospital.

Dr. Overholt Joins Clinic

Dr. Edwin L. Overholt, a veteran of 23 years of active duty with the United States Army, recently joined the medical staff of the Gundersen Clinic–Lutheran Hospital. Doctor Overholt will also be the director of medical education and research for the Adolf Gundersen Medical Foundation. He graduated from the University of Iowa School of Medicine in 1948. He was a regimental surgeon during the Korean War and was assistant chief, department of medicine, 2nd General Hospital in Germany. Doctor Overholt held a similar position at Walter Reed General Hospital in Washington, D. C. and he was a member of the medical team in support of Project Mercury and the orbital flight of John Glenn. Before joining the staff of the Gundersen Clinic–Lutheran Hospital, he was chief, department of medicine, Fitzsimons General Hospital, Denver, Colo., and clinical professor of medicine, University of Colorado School of Medicine.

Dr. Van Hecke Heads Cancer Society

Dr. Leander J. Van Hecke, Milwaukee, recently was reelected president of the American Cancer Society's Milwaukee division.

Dr. Sanson Joins St. Catherine's Staff

Dr. John G. Sanson recently was appointed to the post of associate pathologist at St. Catherine's Hospital, Kenosha. Doctor Sanson was formerly head of the school of medical technology at San Augustin College in The Philippines, and prior to that was a pathologist serving four medical centers in Bacolod City and Iliolo City. Doctor Sanson was named

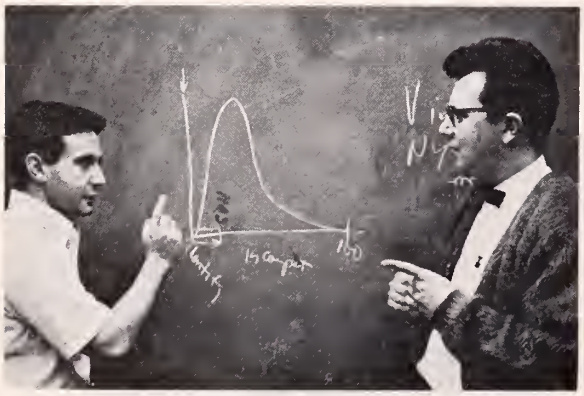
Bone Marrow Transplant Successful at University of Wisconsin Hospitals

For the first time, human bone marrow has been transplanted with predictable success at University of Wisconsin Hospitals, Madison.

Early in November a team of University doctors used a new tissue typing method developed by Wisconsin scientists to predict success in the transplant. The bone marrow of a nine-year-old girl was injected into her two-year-old brother, dying of Wiskott–Aldrich syndrome.

David Zeissett, son of Mr. and Mrs. Donald Zeissett of Chatham, N. Y., had reached the point where he required blood transfusions every other day to stop his bleeding. He suffered from acute brain and intestinal hemorrhaging which reduced his survival chances to almost nothing.

A team of scientists headed by Dr. Fritz Bach, of Wisconsin's Genetics Department tested David and his sister for their blood and tissue compatibility. The tissue matching technique they used had been used previously only in kidney transplants.



Drs. Fritz Bach and Richard Albertini

The researchers found David and his sister's tissues closely compatible and decided to undertake the marrow transplant.

Bone marrow purification steps were directed by Doctor Bach and Dr. Richard Albertini, of Wisconsin and *Dr. Mortimer Bortin* of Mt. Sinai Hospital in Milwaukee.

Although David's condition was dangerously low at one point, all indications now show a marked improvement.

Doctor Bach stresses that the fact of David's survival is the culmination of considerable research conducted by several scientists in the field of medical genetics such as Dr. Donnell Thomas, of Washington University in Seattle, Prof. Robert Good of the University of Minnesota, and Dr. George Santos of Johns Hopkins University.

This achievement offers hope that for the first time it may be possible to effectively treat leukemia, hemophilia, and a host of genetic blood diseases.

The Wisconsin research leading to these achievements was sponsored by the National Institutes of Health, the United States Public Health Service, the Office of Naval Research, and the American Heart Association.

Doctor Bach emphasizes that the procedure is experimental and that David is not yet completely out of danger. He adds, "This breakthrough is only the first step. What we have learned here will be of considerable help in predicting the success of future transplants. However, further basic research will be needed before tissue transplants of this nature become routine therapeutic procedures."

a diplomate to the American Board of Anatomic Pathology in 1963 and a diplomate to the American Board of Clinical Pathology in 1965.

Dr. Gallagher Hosts Vietnamese Physician

Dr. William B. Gallagher, La Crosse, recently had as his guest, Nguyen Tu Vihn, a Vietnamese doctor. Doctor Gallagher worked in his hospital in the southern part of the Mekong Delta. Tu Vihn also visited with other doctors who worked in his hospital and he took medical courses at the University of California. He returned to Vietnam at the end of November.

Dr. Dortzbach Joins Eye Clinic

Dr. Richard K. Dortzbach, Madison, recently joined the staff of the Davis–Duehr Eye Clinic. Doctor Dortzbach graduated from the University of Pennsylvania School of Medicine and interned at University Hospitals and served his residency in Ophthalmology there.

Winnebago Psychiatrists Are Board Certified

Five psychiatrists of the Winnebago State Hospital successfully passed the oral and written examination of the American Board of Psychiatry and Neurology at the Illinois Psychiatric Institute in Chicago, Ill. Those who received Board certification are: *Drs. Richard B. Stafford, John B. McAndrew, Gerald H. Gammell, Ralph K. Baker*, and Thomas Malueg.

Dr. Banyai Awarded Plaque

Dr. Andrew L. Banyai, Chicago, Ill., clinical professor of medicine, emeritus, Marquette School of Medicine, has been awarded a plaque and certificate of merit by the American College of Chest Physicians, sponsor of the Congress, "in recognition of his valuable and devoted service in organizing the scientific program for the X International Congress on Diseases of the Chest" held in Washington, D.C., Oct. 4–8.

Twenty-one from State Elected to FACS

Twenty-one physicians from Wisconsin recently were inducted as new fellows of the American College of Surgeons at the annual five-day Clinical Congress which was held in Atlantic City, N.J. They are as follows: *Drs. Earl J. Roth*, Antigo; *Bruce J. Stochr*, Green Bay; *A. Walid Burhani*, Kenosha; *C. Norman Shealy*, La Crosse; *Richard A. Graf, Gustave C. E. Mueller*, and *George P. Steinmetz, Jr.*, Madison; Charles R. Friend, Marshfield; *John J. Foley*, Menomonee Falls; *Domenick S. Bruno, Robert J. Goldberger, Thomas W. Grossman, W. Dudley Johnson, Allan E. Kagen, Thomas M. O'Connor, James F. Berg*, Joseph E. Gutierrez, and *Stuart D. Wilson*, Milwaukee; *Ralph L. Succhting*, Neenah; *Walter O. Orlow*, River Falls; and *Phillip J. Schoenbeck*, Stoughton.

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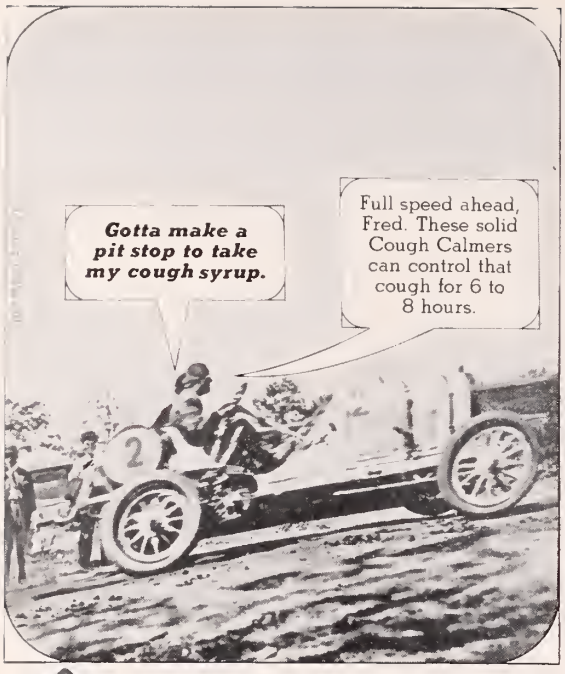

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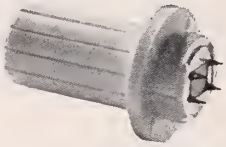

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Drs. Scott and Schaefer Head Cancer Division

Dr. John K. Scott, Madison, and *Dr. F. L. Schaefer,* Neenah, recently were elected to head the American Cancer Society, Wisconsin Division, Inc., as president and vice-president, respectively.

Physicians Reelected to Academy

The following physicians recently were reelected to the active membership in the American Academy of General Practice. They are: *Drs. John W. Schaller,* Biron; *Lyle L. Olson,* Darlington; *Kenneth K. Pavlik,* Edgerton; *F. B. Klaas,* East Ellsworth; *Alvin C. Theiler,* Kiel; *Thomas E. Henney,* Portage; *Robert F. Henkle,* Port Washington; *Frances A. Cline,* Rhinelander; *Russell S. Pelton,* Ripon; *Roland M. Hammer,* River Falls; *Robert A. Keller,* Sheboygan; *Donald V. Moen,* Shell Lake; *Robert J. Meyer,* Spring Valley; *Raymond O. Frankow,* West Bend; and *Donald H. McDonald,* Winneconne.

Dr. Treffert Addresses Auxiliary

Dr. Darold A. Treffert, superintendent of Winnebago State Hospital, addressed members of the Woman's Auxiliary to the Winnebago County Medical Society Oct. 28 on the subject of LSD.

Dr. Bloodworth, Jr. Visits Spain

Dr. J. M. B. Bloodworth, Jr., Madison, recently attended a meeting of an International Symposium on Early Diabetes: Diagnosis and Treatment held in Spain. Doctor Bloodworth presented a paper entitled "Variations in Basement Membrane Width Produced by Aging and Diabetes Mellitus." The proceedings of the meeting will be published in book form. Doctor Bloodworth is the editor of the book, Endocrine Pathology, which was published in September 1968. The book contains chapters authored by *Dr. Stanley L. Inhorn,* Director of the State Laboratory of Hygiene, and Dr. John Opitz, medical genetics, as co-authors of one of the chapters; and Dr. J. H. Turner and Doctor Bloodworth, as co-authors of one chapter.

Bohrod Painting Presented to UW Alumni

An oil painting by Aaron Bohrod was presented to the University of Wisconsin and members of the Wisconsin Medical Alumni Association at homecoming, Nov. 2. Accepting the painting during a special ceremony was Dr. Richard H. Wasserburger, Madison, president of the medical alumni association.

The still life painting is one of the largest works by the UW artist-in-residence. It melds two dozen items peculiar to medical education and the University of Wisconsin Medical Center into a single piece of art. Among the symbols are four buildings known to all Wisconsin physicians—University Hospitals, Science Hall, the McArdle Laboratories, and the Middleton Medical Library.

Mr. Bohrod did several months of historic research and spent three months completing the 24" x 32" painting. It now hangs in the Middleton Medical Library and color reproductions are available to alumni, UW Medical Center faculty, and other interested persons.

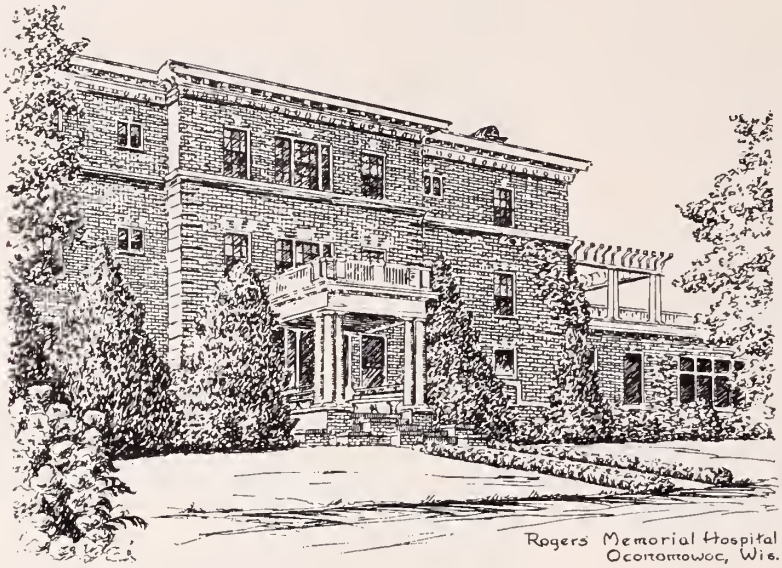
Physicians Address Medical Technologists

Several physicians participated on the program of the annual fall convention of the Wisconsin Association of Medical Technologists Nov. 22–24 in Milwaukee.

Dr. Philip G. Piper, pathologist of Madison General Hospital, Madison, spoke on "How Can Hospitals Become More Involved in Pre-Clinical Education of Medical Technologists."

Dr. Edwin L. Bemis, pathologist of Deaconess Hospital, Milwaukee, presented case histories on Lym-

THE AARON BOHROD presentation of an oil painting to the University of Wisconsin and the UW Medical Alumni Association at a ceremony Nov. 2 was attended by a number of physicians and others, including those shown at right, from the left: Dr. D. J. Freeman, Wausau, past president of the UW Medical Alumni Association; Dr. James W. Nellen, Green Bay, member of the UW Board of Regents; Dr. Peter L. Eichman, dean of the UW Medical School; Dr. John M. Grinde, DeForest; H. Edwin Young, PhD, chancellor of the Madison campus and vice-president of the UW; Mr. Aaron Bohrod, UW artist-in-residence; Dr. Richard H. Wasserburger, Madison, president of the UW Medical Alumni Association. (Photo courtesy UW Medical Center)



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pholeukosarcoma, Acute Promyelocytic Leukemia with Fibrinopathy, Waldenstrom's Macroglobulinemia, DiGugliolmo Syndrome.

"Recent Developments in Our Knowledge of the Rh Antigen" was the subject for *Dr. S. P. Masouredis*, director, Milwaukee Blood Center, Milwaukee.

A Marshfield Clinic physician, *Dr. James W. Manier*, spoke on "Secretory Capacity of the Pancreas and Stomach."

Dr. Mortimer Bortin of the Research Laboratory, Mt. Sinai Hospital, Milwaukee, discussed "Radiation Chimera, Graft v. Host Reactions, and the Ontogenesis of Immune Capabilities" or "How to Cure Cancer, Leukemia and Heart Disease."

Over 300 medical technologists attended the three-day session at the Pfister Hotel. Of particular note was an Instrumentation Workshop at St. Luke's Hospital, scene of the recent heart transplant surgery. Medical technologists were behind the scenes performing important laboratory procedures to aid physicians on the case.

The Milwaukee Society of Medical Technologists was sponsor for the program.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF NOVEMBER 1968

5 Surgical Staff, Madison Gen. Hosp.
5 Madison Urological Society
5 Board of Trustees, Dane Co. Med. Soc.
6 SMS Division on Aging
7 SMS Division on Handicapped Children
7 Central Wisconsin Insurance Project
7 SMS Commission on Public Policy
9 SMS Commission on Medical Care Plans
11 Wisconsin Regional Medical Program
11 Advisory Committee on Extended Care Facilities, Dane Co. Med. Soc.
12 Wisconsin Regional Medical Program
14 WPS Charge Card Corp.
15 Conference on Emergency Care & Transportation of the Injured
15 Ad Hoc Committee on Medical Practice Act
15 Executive Committee of SMS Council
16 Conference on Health Care Costs
16 Comprehensive Health Planning
16 Executive Committee, State Universities Student Health Service Association
20 SMS Section on Ophthalmology—Educational, Legislative, & Executive Committees
25 Insurance Advisory Com., DCMS
26 Health Careers High School Group Tour
27 Cardiology Study Committee, Wisconsin Regional Medical Program

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Wisconsin's First Heart Transplant Performed in Milwaukee Oct. 21

Drs. W. Dudley Johnson and Derward Lepley, Jr. at press conference following Wisconsin's first heart transplant. (Photo courtesy WAUKESHA DAILY FREEMAN)

The first heart transplant in Wisconsin was performed by *Drs. Derward Lepley, Jr.* and *W. Dudley Johnson* Oct. 21 at St. Luke's Hospital in Milwaukee. The patient is Mrs. John Anick who is reported doing satisfactorily.

Doctor Lepley, who heads the heart surgery team at St. Luke's, is an associate professor of surgery at Marquette School of Medicine and chief of thoracic surgery at St. Luke's. Doctor Johnson is assistant professor of thoracic and cardiovascular surgery at Marquette and in thoracic surgery at St. Luke's.

At a press conference two days after the operation Doctor Lepley explained that the techniques used in the operation were basically the same as being used throughout the world for heart transplants.

Others on the transplant team included Drs. Ronald Ramstad, James Romer, and Harold Harding, residents in surgery at St. Luke's; and *Dr. Martin J. Denio, Jr.* anesthesiologist. *Dr. William E. Mateicka*, an assistant anesthesiologist, who normally would have been a part of the team, was in New York at the time of surgery. Other physicians who shared responsibilities with the surgical team were *Dr. John A. Walker*, the patient's personal physician and a cardiologist; *Dr. Donald J. Kuban*, pathologist, who did the initial tissue cross-matching; and *Dr. H. Myron Kauffman* who handled the immunosuppressive therapy.

Five members of the team presented a paper at the annual meeting and scientific session of the American Heart Association in Bal Harbour, Fla., Nov. 21–26. Doctor Johnson is author of the paper, "Pharmacologic Management of Patients Undergoing Coronary Surgery." Co-authors include Drs. Lepley, Harding, Denio, and Mateicka.

COUNTY SOCIETIES

DANE

Annual Election of Officers

The new president-elect of the Dane County Medical Society is *Dr. Donald A. Peterson* following election at the Society's annual meeting Oct. 8 at State Medical Society headquarters in Madison. *Dr. John H. Morledge* is the vice-president and *Dr. Walter R. Sundstrom*, secretary-treasurer. *Dr. Thomas V. Geppert* is the president.

Three new members from the University of Wisconsin Medical School were accepted: *Dr. John D. Pulcini*, resident in general surgery; *Dr. Sigurd E. Sivertson*, associate chairman, Department of Postgraduate Medical Education and assistant clinical professor of medicine; and *Dr. George E. Webb*, assistant professor of Anesthesiology.

KENOSHA

Dr. Klink Addresses Society Members

Dr. Douglas D. Klink, assistant professor of clinical medicine at Marquette School of Medicine, Milwaukee, recently addressed members of the Kenosha County Medical Society on the subject "The Clinical Use of Plasma Cortisols." The group met at St. Catherine's Hospital for dinner and a scientific and business meeting.

CHIPPEWA

"Youth and Delinquency" Meeting Topic

Dr. Jack D. Edson, director of the Lorenz Institute at Eau Claire, addressed members of the Chippewa County Medical Society Nov. 5 at Chippewa Falls. His topic was "Youth and Delinquency."

WAUSHARA–GREEN LAKE

UW Professor Speaks

The Oct. 22 meeting of the Waushara–Green Lake County Medical Society was held at Montello with the guest speaker being Dr. Robert Goldstein, professor of rehabilitation medicine, University of Wisconsin Medical School, Madison. He spoke on "Hearing Difficulties in the Young and Aged."

SPECIALTY SOCIETIES

Milwaukee Neuro-Psychiatric Society

An internationally prominent neurosurgeon, Dr. Lyle A. French, was guest lecturer at the Nov. 20 meeting of the Milwaukee Neuro-Psychiatric Society.

Other speaking engagements for that day included one for the Marquette School of Medicine Department of Neurosurgery and another for the medical staff of Milwaukee County General Hospital.

Doctor French is director of the Division of Neurosurgery at the University of Minnesota School of Medicine and is chief-of-staff at their University Hospitals.

Wisconsin Academy of General Practice

About 50 general practitioners and psychiatrists joined together Oct. 23 at Oshkosh for a symposium aimed at fostering mutual understanding between the two groups.

Sponsored jointly by the Wisconsin Academy of General Practice, Winnebago State Hospital, and a national pharmaceutical company, the program included the following topics: "Care of the Aging and the World of the Nursing Home," "How to Use a Psychiatric Consultant," "Alcoholics and the Role of the Community Medical Practitioner," and "What Bothers Me About the General Practitioner or Psychiatrist."

On the program were Dr. Thomas Kelley, clinical director; *Dr. Darold A. Treffert*, superintendent; and Dr. George Lysloff, assistant clinical director, of Winnebago State Hospital; and *Dr. Gerald J. Derus* of Madison, president of the WAGP.

LEADERS IN SYMPOSIUM for general practitioners and psychiatrists Oct. 23 in Oshkosh are from left: Dr. Gerald J. Derus, Madison, president of the Wisconsin Academy of General Practice; Dr. Darold A. Treffert, superintendent of Winnebago State Hospital; and Dr. George O. Lysloff, assistant clinical director of WSH. (Photo courtesy OSHKOSH NORTHWESTERN)

Physicians whose names appear in italics are members of the State Medical Society.

SECTION OPHTHALMOLOGY

DECEMBER 1968 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

SOME RECENT ADVANCES IN OPHTHALMIC PLASTIC SURGERY

RICHARD K. DORTZBACH, M.D., Madison, Wisconsin

I RECENTLY HAD the privilege of spending a six-month precepteeship in ophthalmic plastic surgery with Dr. Alston Callahan in Birmingham, Ala., and the procedures I will discuss and illustrate with patient photographs, therefore, reflect his current methods of treating some of the most difficult problems in this field. These techniques are covered in more detail in the recently published books by both Doctors Callahan and Mustarde.

Since the scope of ophthalmic plastic surgery is so broad, I will confine this discussion to the following three main topics: (1) Full-thickness lower and upper lid reconstruction, primarily using "the Mustarde System;" (2) blepharophimosis; and (3) intractable blepharospasm.

(1) In full-thickness lid reconstruction Mustarde has devised a method whereby the lower lid is used to reconstruct the upper lid, and other tissues are rotated to reconstruct the lower lid. The upper lid must have mobility to protect the eye and is, therefore, more important to preserve than the relatively stationary lower lid. For this reason, it is a good principle not to use the upper lid to rebuild the lower lid, as with the Hughes procedure, and thereby risk damaging the upper lid.

Mustarde had scientifically simplified upper and lower lid reconstruction by basing it on multiples of ¼. If ¼ of either lid is lost, there is enough elasticity in the remaining lid tissues to allow the wound edges to be brought together for primary closure. If ½ of the lower lid is lost, a zygomatic flap is rotated to build the lid. For ¾ or total lower lid loss, a large cheek flap must be used. In the more extensive cases the inner surface of the reconstructed lower lid is lined with a buccal mucosal graft obtained with a Castroviejo electromucotome. If the lacrimal puncta and canaliculi are lost along with the medial portion of the lower lid, a pyrex Jones tube may be put in place later to provide tear drainage from the inferior cul-de-sac into the nose.

For an upper lid defect greater than ¼, Mustarde rotates tissue from the lower lid upward in the form of a full-thickness pedicle flap. Great care must be taken not to twist or put tension on the pedicle and thereby compromise its blood supply. The pedicle is divided after two and one-half to three weeks. Because one may discount the initial ¼ of upper lid lost, it is never necessary to mobilize more than ¾ of the lower lid even in total upper lid reconstruction, and, therefore, the inferior lacrimal punctum and canaliculus in the medial ¼ of the lower lid may always be preserved. The lower lid is then rebuilt by rotating in the appropriate zygomatic or cheek flap, as described above.

(2) Blepharophimosis is a congenital defect in which the palpebral fissure is narrowed both horizontally and vertically. The characteristic triad consists of epicanthus inversus (epicanthus base in lower lid), telecanthus (medial canthi laterally displaced), and ptosis. The epicanthus inversus is corrected by the Mustarde quadrilateral flap method. Telecanthus correction involves resection of a portion of the medial canthal tendon. The Jones technique of levator resection is used to correct the ptosis. This anterior (skin) approach to the levator involves much less dissection than other anterior approach methods. It also gives better exposure and is less prone to complications, such as upper lid entropion, than the posterior (conjunctival) approach to the levator.

(3) Intractable blepharospasm is an uncommon but incapacitating affliction. The most effective treatment found so far has been identification, division, and avulsion of the distal portions of the facial nerve branches to the orbicularis muscle. The small incision for this procedure is made over the main trunks of the facial nerve just anterior to the ear. A physiologic nerve stimulator is indispensable in identifying the appropriate nerve branches. Care must be taken to avoid paralytic ectropion or drooping of the corners of the mouth resulting from avulsing too many or incorrect facial nerve branches. The patients who seem to benefit most by this operation are those who have frequent, severe squeezing of the lids. Those with just a facial tic are less likely to be helped significantly.

Summary of an address given at the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, Bailey's Harbor, Wis. Sept. 20, 1968.

VOLUNTARY DUES ASSESSMENT

The Executive Committee would like to remind all ophthalmologists that voluntary dues for the year 1969 are still being received. The regular membership contribution is $100.

Checks are payable to: Section on Ophthalmology. Mail to: State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

PARAMEDICAL/ANCILLARY

State Medical Assistants Society Receives Publication Award

MILDRED GEDAKOVITZ (right), Waukesha, accepts the second place publications award in the "states with membership over 200" category from Wilda Haines, Canton, Ohio, awards chairman of the American Association of Medical Assistants. Mrs. Gedakovitz, editor of the *Wisconsin State Medical Assistants Society Bulletin*, accepted the award at AAMA's 12th annual convention in Columbus, Ohio, Oct. 9–12.

Medical Assistants Attend Convention

Seventeen medical assistants from Wisconsin attended the 12th annual convention of the American Association of Medical Assistants Oct. 9–12 in Columbus, Ohio.

Nationally prominent physicians addressed themselves to the convention program which had as its theme "Progress through Professionalism." Some of the subjects covered were "The Office Carousel—Patient, Assistant, Physician," a symposium on the art of patient relations and the importance of the medical assistant as the middle link; "Quackery in the Health Field," an explanation of the AMA's Investigation Department which serves as a clearinghouse for information on 'patent medicines,' quacks, medical fads, and various other phases of pseudomedicine; and a symposium on "Cost of Medical Care."

Delegates from Wisconsin were: Mrs. Jane Staszewski, CMA, Big Bend; Miss Phyllis Schirmer, Milwaukee; Miss Donna Schultz, Menasha; Mrs. Peggy Gallagher, CMA, Waukesha; Mrs. June Gillette, CMA, Sheboygan; and Mrs. Aleen Piepenburg, Madison.

Physicians whose names appear in italics are members of the State Medical Society.

Assistants Educational Symposium Set

Plans are being made by Mrs. Aleen Piepenburg of Madison for the annual state educational symposium of the Wisconsin State Medical Assistants Society. It will be held Feb. 1, 1969, at the Pfister Hotel in Milwaukee. *Dr. Anthony R. Curreri*, director of the Division of Clinical Oncology, and professor and chairman of the Department of Surgery, University of Wisconsin Medical School, will be the featured speaker.

A leadership training seminar for members was held Sept. 14 at the Holiday Inn, Wausau. Keynote speaker was Russell R. Ross, director of education, Employers Insurance of Wausau, whose topic was "Qualities of Leadership." Panel discussions on membership recruitment and maintenance, parliamentary procedures, and a workshop for officers were part of the seminar. Mrs. Anita Mirkes of Wausau was chairman.

State Nurses on National AHA Program

Two nurses from Madison were program participants in the Clinical Nursing Conference of the American Heart Association in Miami Beach, Fla., Nov. 22–23.

Miss Dona Gilbo, RN, instructor and supervisor of medical nursing, University of Wisconsin School of Nursing, was a panel participant in the program, "Changing Responsibilities of Nurses and Physicians in the Care of the Cardiac Patient."

Mrs. Signe S. Cooper, RN, chairman, Department of Nursing, University of Wisconsin, moderated the panel, "Changing Concepts of the Delivery of Health Services." Mrs. Cooper is a member of the Committee on Nursing Education of both the American Heart Association and the Wisconsin Heart Association.

Other nurses from Wisconsin who attended the AHA convention are Miss Sylvia Bailey, RN, University Hospitals, Madison; Mrs. Shirley Duwe, RN, Miss Sally Esther, RN, Mrs. Carol Grandberg, RN, and Mrs. Diane Stram, RN, all of St. Luke's Hospital, Milwaukee.

Multiple Sclerosis Group to Meet

The Central Wisconsin Chapter of the National Multiple Sclerosis Society will hold its annual meeting Jan. 12 at 2:00 p.m. at the State Medical Society headquarters in Madison (330 East Lakeside Street). Three guest speakers from the University of Wisconsin Medical Center will present lectures on current research and perspectives in multiple sclerosis.

WISCONSIN MEDICAL JOURNAL
VOL. 67, NO. 12 DECEMBER 1968

Medical
GREEN SHEET
NEWS OF SOCIO-ECONOMIC MEDICINE

Must Keep Health-Care Costs from Skyrocketing Conferees Told at Nov. 16 Meeting in Madison

Expenditures for personal health-care services in Wisconsin are currently estimated at $1.025 billion annually and they may reach $2 billion by 1975.

Facts and "estimates" such as these were among the many interesting developments during the roundtable discussion of health-care costs in Wisconsin held at the headquarters of the State Medical Society Nov. 16.

Sponsored by the State Medical Society and presented under the chairmanship of Dr. W. D. James, president, Oconomowoc, and Dr. R. E. Callan, president-elect, Milwaukee, the meeting attracted more than 50 physicians and other health-care providers along with many outstanding citizens interested in health care in the state.

Society to Provide Impetus

In concluding the meeting, the participants unanimously agreed that the State Medical Society should continue to provide the impetus for discussions on how to cope with rising health-care costs.

Dr. Callan agreed to appoint a continuing committee representative of the broad interests of the health professions and the public to "get specific" in dealing with problems associated with health-care costs.

The meeting was called by the State Medical Society as a follow-up of an Oct. 24–25 meeting held at Cleveland, Ohio, under the direction of the Secretary of the U.S. Department of Health, Education, and Welfare.

The feeling of many roundtable attendees was summarized by Robert Gavin, Milwaukee, a representative of the United Auto Workers who said, "I don't believe we feel health-care costs are excessive at this point, but the real question is how to keep them from skyrocketing. We are not here to reduce existing costs but to help hold down the future rise."

Warren Von Ehren, Madison, executive director of the Wisconsin Hospital Association, challenged the group to consider whether "costs are really excessive—compared to what?"

He continued by pointing out that the cost of education, government, local property assessments, and many other services and products have gone up in price at a far more rapid rate than health care. "The big problem is that we are selling a product which no one really wants to buy," he said.

Labor Costs Major Factor

Several participants pointed to rapidly rising labor costs in hospitals as a major contribution to rising health-care costs. Miss Helen Bunge, RN, Madison, pointed out that 70% of the hospital's charge is a labor cost for employees. She pointed out that many hospital workers three years ago received only $.90 per hour while they are now required to provide at least $1.70 minimum wage. Nurses who three years ago received about $360 per month now are receiving $525 per month. She pointed out that hospitals have lagged in paying the going rate for labor in the community and much of the increased cost today is due to efforts to catch up.

Wilbur Schmidt, Madison, director of the State Department of Health and Social Services, urged that attention be given to: (1) internal efficiencies in the operation of Medicare, Medicaid, and health services in general, and (2) elimination of dupli-

(Continued on page 35)

SMS COSPONSORS SAFETY CONFERENCE

The State Medical Society of Wisconsin is one of the cosponsors of the Wisconsin Council of Safety's conference on "Highway Safety" scheduled for Monday, Jan. 27, from 9 a.m. to 4 p.m. at the Park Motor Inn in Madison.

The Society's Commission on Safe Transportation and Commission on Hospital Relations and Medical Education have offered the services of physicians for program participation.

Cooperation and Understanding, Vital Links to Success of Comprehensive Health Planning

"We are seeing only the top of the iceberg."

This was the comment echoed by many of the 85 physicians as they left the Nov. 16 meeting called by the State Medical Society to discuss comprehensive health planning.

The physicians who attended all were involved in statewide or local aspects of planning for comprehensive health care under Public Law 89–749.

The State Medical Society called the meeting as a means of providing a forum for physicians who seek to expand their knowledge of the comprehensive health planning law and their experiences at the local level in attempting to implement the program.

Challenge to Become Active

Dr. H. G. Bayley, Beaver Dam, member of the State Medical Society's Council, challenged physicians to become active even though they are by law limited to minority representation in comprehensive health planning bodies. "I believe that our being knowledgeable, interested, and energetic will make up for our lack of numbers," Dr. Bayley said.

He felt that MDs should be the prime determiners of the comprehensive health planning area boundaries. He suggested that MDs combine with others in their area to recommend the area boundaries, a knowledgeable and active person as chairman, and then begin activities for funding.

Education of county board members is the first step toward development of a sound area planning program, according to Dr. C. F. Broderick of Wisconsin Dells.

Dr. George H. Handy, Madison, director of the State Bureau of Comprehensive Health Planning, reported that nearly 1,000 persons had attended six areawide planning meetings. Among them were nearly 150 physicians. He said, "Physicians should take the leadership in creating areawide planning groups, but such has not been the tradition of physicians in the last several decades."

Mention of chiropractic efforts to involve themselves in planning comprehensive area activities stirred up substantial interest. Dr. George B. Murphy, Jr. of La Crosse declared, "I can't condone expenditures of public funds and physicians' time to work with chiropractors on health planning. We ought to outlaw them."

Lots of time, a good deal of listening, great patience, and elasticity will be required of physicians who serve in the comprehensive health planning program, according to Dr. R. E. Callan, Milwaukee, president-elect of the State Medical Society.

"The pay-off will depend on how well doctors operate in community work and education of the public," he said.

HANDICAPPED CHILDREN DIVISION TOLD OF INNER CORE PROGRAM

A hearing screening program in the inner core of Milwaukee initiated by the State Bureau for Handicapped Children was explained to members of the State Medical Society's Division on Handicapped Children which met Nov. 7 at the SMS headquarters in Madison.

The research project involves 600 children in the core area and 300 outside. Attempts are being made to provide similar backgrounds for these children so that valid comparisons may be made. Approximately 5% of the youngsters screened "failed" the hearing test. It is planned to provide an audiologist for follow-up of those who need additional testing.

Discussion followed with respect to the new devices available, and their use in testing reaction and, thereby, hearing of newborns.

In other items considered, the Division acknowledged its continued interest in a survey of prices for braces and prostheses and the qualifications of the appliance vendors.

The Division urged cooperation of county medical societies in organization of pediatric clinics which are in the process of being developed in the Ashland area and possibly the Door county area by the Bureau for Handicapped Children. The Bureau has added a pediatric nurse to its staff in establishing these clinics.

It was announced that the Division on Handicapped Children, together with the Division on Vision, has been invited by the Bureau to hold a joint meeting in the early spring of 1969 at the School for the Deaf and the School for the Blind at Janesville and Delavan. Dr. Horace K. Tenney, III, medical director of the Bureau, is making arrangements.

Members of the Division in attendance were: Drs. John J. Suits, chairman, Marshfield; Arthur A. Siebens, Robin N. Allin, Frank Bernard, Gertrude E. Howe, and Tenney, Madison; and Dr. Ray R. Rueckert, Portage.

MEDICAL ASSISTANTS SET EDUCATIONAL SYMPOSIUM

Plans are being finalized by Mrs. Aleen Piepenburg of Madison for the annual educational symposium of the Wisconsin State Medical Assistants Society set for Feb. 1 at the Hotel Pfister in Milwaukee.

Dr. Anthony R. Curreri, director of the Division of Clinical Oncology and professor and chairman of the Department of Surgery, University of Wisconsin Medical School, will be the featured speaker.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio–economic interest to physicians and others.

Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1968 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Earl R. Thayer, Director of Socio–Economic Medicine.

Urges Health Services for Small Plants

Industry must be sold on the value of organizing employee health services in small industries, utilizing common personnel—nurses and physicians—and be willing to pay for these services.

This was the conclusion of members of the Committee on Occupational Health of the Division on Rehabilitation when it met recently at the State Medical Society headquarters in Madison.

Several guides for smaller plants in industry were distributed to the Committee by Dr. George H. Handy, director of the Bureau of Comprehensive Health Planning of the State Division of Health.

After agreeing that the problem of the cardiac patient in industry is practically non-existent, the Committee suggested that the research project undertaken by Dr. George A. Hellmuth, entitled, "Heart Disease in Industry," under sponsorship of the Society's CES Foundation, be reconsidered.

Further discussions centered around industrial programs, immunizations, tuberculosis control, and incidence of hepatitis.

The Committee was advised of pending federal legislation in which the Department of Labor is advocating a program which would initiate standards for all toxic agents at a federal level, to be applied throughout the nation.

At a recent meeting in Washington the American Medical Association appeared against this program, but was not completely successful.

The Committee directed its chairman, Dr. James M. Wilke, Madison, to inform Wisconsin's congressmen and senators, as well as other interested persons, that it favors broad federal guidelines under medical sponsorship with the individual states cooperating to establish their own programs within the framework.

Plans were discussed for a Conference on Pesticides and Insecticides and a Seminar on Rehabilitation of the Occupational or Industrially Injured Person to be held in 1969.

The Committee is considering development of a standard approved pre-employment physical examination form for use in industry.

Two new members of the Committee: Drs. William A. Nielsen, West Bend, and Donald M. Rowe, Kohler, were introduced at the meeting which was also attended by: Doctors Wilke, William W. Ford, Green Bay; John V. Flannery, III, Wausau; Carl Zenz, West Allis; and Allen G. Brailey, Jr., La Crosse.

Doctor Handy was a guest.

Dr. Nereim Elected to AAGP Post

Dr. Theodore J. Nereim of Madison recently was elected vice-president of the American Academy of General Practice. He just completed a three-year term on the AAGP Board of Directors. Dr. Nereim is vice-speaker of the State Medical Society of Wisconsin House of Delegates.

HEALTH-CARE COSTS

(Continued from page 33)

cation of services within hospitals and other health facilities and to patients. He suggested that waiting for "people to move may take years and it may be necessary in some areas to get results through government action."

Dr. E. J. Nordby, Madison, chairman of the Council of the State Medical Society, urged that more attention be given to providing "housekeepers" for patients as a means of reducing the costs of health care. He pointed out that many patients will not and cannot leave hospitals and nursing homes without some provision for housekeepers and meal services at home.

Standardization of health insurance policies, incentive plans for hospital costs, and greater availability of beds for both hospitals and nursing homes were urged as prime considerations by Dale Jennerjohn, Madison, of the staff of the State Division of Health. He urged greater use of residential care facilities to assist with lowering costs for persons eligible for Title XIX benefits.

Considerable discussion took place with regard to utilization review committees and their role in costs.

In concluding the meeting Dr. Callan indicated that he would make an early announcement of the membership of a continuing committee to study health-care costs and make recommendations.

MEMO TO PHYSICIANS

ABCs of CHAMPUS

Civilian Health and Medical Programs of the Uniformed Services

ALWAYS REPORT services promptly while patient is available for any further details which may be required before claim can be paid. Some CHAMPUS dependents move frequently.

BEGIN BY securing all necessary identification data and the required signatures on the patient's first visit if at all possible; otherwise, at the very first opportunity.

CONTINUE BY making certain that your report lists all services, charges, dates and diagnoses and that there is sufficient detail to establish both the reasonableness of charges and the payability of the claim.

(CHAMPUS was formerly known as Military Medicare. By contract with the federal government the WPS division of the State Medical Society of Wisconsin performs the administrative functions in Wisconsin.)

Coverage of Ambulance Service in Medicare–Part B Clarified

Physicians throughout Wisconsin are charging that federal Medicare regulations on the use of ambulance services are "frustrating," "ridiculous," and an "infringement of the physician's responsibility to his patient."

The controversy arises out of Medicare–Part B regulations which require that, to be eligible for Medicare payment, ambulance service may be used only to transport a patient to "the nearest hospital with appropriate facilities."

Must Adhere to Rules

Under current conditions, Wisconsin Physicians Service, the Blue Shield division of the State Medical Society which acts as Part B–Medicare carrier for the Social Security Program in Wisconsin, except Milwaukee county, can do nothing more than administer the rules and regulations as they are now set up. At the same time the State Medical Society is seeking to protest the regulations on the basis that they are not realistic.

In the meantime, Donald J. McIntyre, director of the WPS Medicare Claims Department, offers the following explanation as required under present rules and regulations:

Under Part B of Medicare for coverage of ambulance services, each of the following three conditions must be met:

1. The vehicle utilized and the ambulance personnel must be certified as meeting the minimum requirements as provided under Part B of Medicare.
2. Ambulance service is covered only where the use of any other method of transportation is medically contraindicated by the patient's condition.
3. The patient must have been transported to: (a) the nearest hospital with appropriate facilities; or (b) to another hospital with appropriate facilities whose locality encompasses the place where the ambulance transportation of the patient began. The patient may be transported under similar restrictions from one hospital to another or to an extended care facility, or from one of these institutions to his home if it is within the locality of the institution from which he is transported.

These requirements are intended to provide coverage of essential ambulance service without imposing an arbitrary "mileage" limitation.

WPS experience in administering claims for ambulance service under Part B of Medicare indicates that the greatest area of misunderstanding of the coverage involves the term "appropriate facilities."

The term "appropriate facilities" means that the institution is generally equipped to provide medical care for the type of illness or injury involved. The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities."

It is the hospital, its equipment, its employees and its capability to provide medical care that determine whether it has "appropriate facilities." The physicians who practice in a hospital are not a consideration in determining whether the hospital has "appropriate facilities." Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or a physician in a specific specialty does not make the hospital in which the physician has staff privileges the nearest hospital with "appropriate facilities."

PLANS SET FOR PROGRAM PROBLEMS OF ALCOHOLICS

Plans for a 1969 conference on the care and treatment of the alcoholic in the general hospital were reviewed at an Oct. 17 meeting of the Division on Alcoholism and Addiction of the State Medical Society.

The program is to be presented under the sponsorship of the Division of Alcoholism Services of the State of Wisconsin, and the State Medical Society will participate as a cosponsor.

The Society Division also discussed a program dealing with the medicolegal aspects of alcoholism and drug abuses which is scheduled for June 6, 1969, at the Pioneer Inn in Oshkosh.

Efforts to expand insurance coverage for alcoholics were reported under way through the activities of an Advisory Committee to the State Alcoholism Services Division.

PHYSICIAN SHORTAGE CONFERENCE DEC. 14

A Town and Gown Symposium for the spring of 1969 was considered by the Commission on Hospital Relations and Medical Education at a recent meeting at State Medical Society headquarters in Madison.

Medical public relations and the image of medicine were topic proposals.

A conference to develop proposals to relieve the shortage of physicians in Wisconsin was set for Dec. 14 at the SMS.

The Commission was given an initial report of the Bureau of Comprehensive Health Planning, State Division of Health, on study and categorization of hospital emergency rooms.

Other subjects discussed but with no formal action taken were the role of the registered nurse in the coronary care unit and the rejection of worthy students to medical schools.

Attending the meeting were: Drs. George B. Murphy, Jr., La Crosse, chairman; L. W. Schrank, Waupun; A. J. Richtsmeier, Madison; R. S. Galgano, Delavan; Philip G. Piper, Madison; Dale V. Moen, Shell Lake; and George W. Hilliard, Milwaukee.

Dr. William D. James, Oconomowoc, president of the State Medical Society, was also present.

REVIEW COMMITTEE OF REGIONAL MEDICAL PROGRAMS

Robert E. Jones—Dr. David G. Green—Glenn G. Lamson, Jr.—Dr. Frank R. Mark—Dr. George E. Miller—Dr. Donald P. Pinkel

RMP Review Committee Visits Wisconsin

Representatives of the Grants Review Section of the Health Services and Mental Health Administration reviewed activities of the Wisconsin Regional Medical Program (WRMP) during a site visit Nov. 10–12.

WRMP staff and committee members, directors of operational projects, and prinicpal applicants of projects presently under review in Washington met with the review committee at the State Medical Society headquarters in Madison.

Reviews Program

Dr. John S. Hirschboeck, WRMP program coordinator, told the committee of the accomplishments and future plans of the program which began in 1966.

"We have come a long way during the past two years in achieving our goal," Dr. Hirschboeck said. "However, there still are many rough roads which must be traveled. Too many physicians and hospital administrators are unaware of the facilities and services available to them in other areas of the state. In some areas, the facility they require for a particular function is located no more than a few miles away from their locale," he explained.

"Since we have begun working with the various medical units and individuals, we have found a great deal of cooperation and surprise on their part," Dr. Hirschboeck stated. "The surprise came about because they were unaware of the advanced activities in other areas of the state to which they might have access. The cooperation came about because it would eliminate a great deal of duplication of services and the consequent need for expensive medical equipment to achieve results already being received on a routine basis in other areas of close proximity."

Dr. Hirschboeck explained that, because of WRMP, northern Wisconsin physicians and hospitals are realizing that through a corporate effort advances in medical science can be brought to the people, and this is the purpose of WRMP. There is a meshing of technical knowledge and services for the benefit of all concerned including the patient, he added.

Made Great Strides

T. A. Duckworth, senior vice-president and secretary of Employers Insurance of Wausau and a member of the regional advisory committee of WRMP, reported that his committee has made great strides forward during the past year.

"We have formulated several plans of action in all geographical and functional areas and have begun to put them into motion," Mr. Duckworth said. "We have run into problems or difficulties in some of the areas; however, nothing major, nothing that can't be resolved."

Projects reviewed by the committee were the studies on uterine cancer, continuing education, pulmonary thromboembolism, cardiovascular disease, cancer chemotherapy, tissue typing, stroke rehabilitation, nursing, radiology, hypertension, and uterine cytology.

The request to the federal program by the Wisconsin Regional Medical Program for continuation of projects amounted to $2,358,500.

The review committee consisted of.

Dr. George E. Miller, director, office of research in medical education; College of Medicine, University of Illinois, Chicago;

Dr. David G. Greene, professor of clinical research in cardiovascular disease, Buffalo General Hospital, Buffalo, N. Y.;

Dr. Donald P. Pinkel, medical director, St. Jude's Hospital, Memphis, Tenn.;

Dr. Frank R. Mark, acting chief, Operations Research Branch, Bethesda, Md.;

Mr. Glenn G. Lamson, Jr., acting chief, operations staff, Office of the Associate Director of Operations, Bethesda, Md.; and

Mr. Robert E. Jones, public health advisor, Grants Review Branch, Bethesda, Md.

MEMO from WPS

Physicians! Please do NOT use the SSA 1490 claim form for filing for services rendered any person UNDER age 65. Using this form erroneously causes increased administrative expenses for WPS, delays in claim processing, and consternation by the government in handling the Medicare system.

WRMP to Help with Physician Education

The Commission on Scientific Medicine at a recent meeting unanimously endorsed and gave full support to a program of physician education proposed by the Wisconsin Regional Medical Program (WRMP).

Dr. John S. Hirschboeck, program coordinator, emphasized that continuing education of the physician is a primary objective of the WRMP.

A health manpower proposal provides for intensive postgraduate education in the various specialties. This would involve the physician returning to the medical school for a residency type of program.

Dr. Marion Mykytew, assistant program coordinator (Marquette), said the proposal seeks to establish (1) a Department of Health Manpower, (2) continuing education at Marquette, (3) clinical internships in internal medicine, and (4) a program of linking clinical trainees with the medical school through such things as (a) audio-visual tape reviews on a quarterly basis, (b) community technical consultation service, (c) workshops, (d) regional conferences, (e) TV programs, (f) telephone conferences, and (g) joint clinical studies (cancer chemotherapy).

SMS and WRMP to Cooperate

It was agreed that the State Medical Society and the Wisconsin Regional Medical Program would cooperate in presenting circuit teaching programs primarily in areas of the State in which postgraduate education is difficult to obtain.

A stipend or per diem to physicians who attend one or more of these continuing education programs has been established by the WRMP. The per diem, which cannot exceed $50 per day, is intended primarily to assist the physician in providing patient care during his absence.

Plans for the 1969 SMS annual meeting were reviewed and further suggestions considered. The Commission accepted an offer by the Wisconsin Regional Medical Program whereby it will financially support selected speakers at the annual meeting, provided postgraduate educational funds are available from approved operating projects of WRMP and that subjects relate to heart disease, cancer, stroke, or related diseases.

Dr. Edgar S. Gordon, chairman of the Commission, stated that while much of the program will remain scientific there are current suggestions being considered in the socio-economic area which need broad and intensive consideration by the medical profession.

Other Commission members attending were: Drs. Jack A. Killins, Green Bay; Anthony V. Pisciotta, Milwaukee; Ben R. Lawton, Marshfield; Gerald J. Derus, Madison; Einar R. Daniels, Wauwatosa; Norman O. Becker, Fond du Lac; Sigurd E. Sivertson, Madison; Peter L. Eichman, Madison; and Gerald A. Kerrigan, Milwaukee.

Also present were Dr. William D. James, Oconomowoc, president of the State Medical Society; and Dr. Eugene J. Nordby, Madison, chairman of the Council.

Invited guests were representatives of the Wisconsin Regional Medical Program: Doctors Hirschboeck, Mykytew, and Thomas C. Meyer; and Mr. Roy T. Ragatz.

AT A JOINT MEETING of the Winnebago County medical and dental societies in November at Oshkosh, Dr. Anthony R. Curreri urged his audience to make Wisconsin more attractive to graduating medical students. In speaking of the "critical" medical manpower shortage in the state, especially in rural areas, the University of Wisconsin surgeon said that UW medical students "don't know enough about the opportunities offered" in the state. Dr. Curreri stressed the need for cooperation between local communities and their hospitals, the University, and the State Medical Society. He made two suggestions: (1) Secondary medical clinics could cooperate with community hospitals which in turn could cooperate with the UW's medical school, thereby creating an improved training ground for the new doctors, and (2) Higher pay in community hospitals, which again would attract more new doctors. This "marriage between the community hospital and the university medical center" could result in more meaningful training of young doctors and a greater service to the state, he contended. Shown above with Dr. Curreri are (from left): Drs. Michael Weinzierl and W. C. Bush, Berlin, president and secretary, respectively, of the dental society; Dr. George Arndt, Neenah, secretary of the medical society; Dr. Curreri, chairman of the department of surgery and professor of surgery for 27 years at the UW; and Dr. Eugene N. Wright, Oshkosh, president of the medical society.

TEACHING HEALTH THROUGH STAMPS

A collection of postage stamps is the newest health education device being employed by the CES Foundation of the State Medical Society.

Now numbering more than 3,000 issues, the collection is limited to stamps which commemorate occasions of public health achievement or memorialize physicians and other scientists who have contributed to the progress of medicine.

The Foundation uses the stamps to illustrate talks on health careers, the progress of medicine, and problems of public health.

Name Officers for Advisory Committee, WRMP

Judge Rodney Lee Young of Ladysmith has been named chairman of the regional advisory committee of the Wisconsin Regional Medical Program.

Also named officers of the committee are: W. C. Proctor, manager of industrial relations for Uniroyal of Eau Claire, vice-chairman; and Dr. Leander J. Van Hecke, president of the Milwaukee Division of the American Cancer Society, Milwaukee, medical vice-chairman.

The 40-member advisory committee helps direct the activities of the WRMP, a cooperative program through which medical schools, hospitals, clinics, physicians, nurses, voluntary health organizations, and others throughout the Wisconsin area receive and give each other faster and more thorough assistance in combating heart disease, stroke, cancer, and related illnesses.

Also named to the committee are: Harold E. Bliss, vice-president of Employers Insurance of Wausau; R. J. Halvorsen, president of Hamilton Manufacturing Co., Two Rivers; Philip J. Hendrickson, Krueger Metal Products, Green Bay; Richard L. Johnson, president, Menasha Corp., Neenah; and Wesley J. Mooney, Wisconsin Telephone Co., Racine.

The following, all from Milwaukee, were also named: Gordon L. Berry, assistant to the vice-president for academic affairs, Marquette University; Dr. Mark J. Cicantelli; Mrs. Robert E. Dineen, chairman, health facilities liaison committee, Hospital Area Planning Committee; Willis A. Erasmus, member, Milwaukee County Board of Welfare; Edwin J. Klag, director, Veterans Administration Center; Dr. Ross C. Kory, president, Wisconsin Heart Association; and Dr. John R. Petersen, director of medical services, Milwaukee County General Hospital.

Name Members to New Committees

Chairman of the SMS Council, Dr. E. J. Nordby of Madison, recently announced appointment of members to two newly created committees of the Society as follows:

Committee on Medicine and Religion: Drs. John O. Simenstad, Osceola, chairman; R. W. Shropshire, Madison; F. J. Cerny, Fond du Lac; Maxwell Weingarten, Milwaukee; and Joseph R. Matt, Oconomowoc.

Commission on Health and Natural Resources: Drs. David L. Morris, West Salem, chairman; S. J. Graiewski, Oshkosh; O. A. Sander, Milwaukee; Maurice G. Rice, Stevens Point; John Noble, Black River Falls; John B. Davis, Madison; R. J. Sneed, Ashland; George W. Dean, Milwaukee; and Louis W. Chosy, Madison.

DRS. HUFFER, RUNDLE NAMED TO SAFE TRANSPORTATION

Motorcycle safety, driver licensing, alcohol in relation to highway safety, and emergency medical services were subjects discussed at a recent meeting of the Society's Commission on Safe Transportation.

Dr. James L. Weygandt of Sheboygan Falls, chairman, reported on the AMA conference on "Medical Goals for Automotive Safety" held this fall in Washington, D. C.

Purpose of the conference was to develop definite and practical goals for the medical profession in the field of automotive safety.

Two members of the Commission, Drs. Frederick Bunkfeldt, Jr. of Milwaukee and Joseph D. Farrington of Minocqua, were appointed as an advisory committee to the program planning committee for an Orthopedic Seminar on Care and Transportation of the Sick and Injured scheduled for 1969 in Madison.

Two new members were named by the Chairman of the Council. They are Drs. James M. Huffer and Frank L. Rundle of Madison. Both will serve three-year terms.

Attending the meeting were Doctors Weygandt; Ralph F. Hudson, Eau Claire; Bunkfeldt; Walter F. Smejkal, Manitowoc; and Glenn C. Hillery, Lancaster.

Also attending were Dr. Arthur L. Van Duser and Donald Gehrman of Madison, representing the State; and Drs. Clemens G. Kirchgeorg of Neenah and Ralph T. Sproule of Milwaukee, representing the Society's Division on Vision.

DIVISION ON AGING INITIATES BETTER LIAISON IN STATE

The Division on Aging, which met Nov. 6 at the State Medical Society headquarters in Madison, reviewed home health services available in Wisconsin and noted that 42 counties provide homemaker services under Title 19 of the Medicare law.

The Division is encouraging the use and coordination of information on these services.

Other matters considered were the medical aspects of nursing home operation and the flexible approach to retirement rather than the mandatory approach that is now common.

After reviewing the activities of the Advisory Committee on Professional Services of the Wisconsin Council of Homes for the Aging, the Division agreed that the State Medical Society's representative to this Committee, Dr. David N. Goldstein, Kenosha, be invited as a consultant member to the Division on Aging.

Further liaison with other groups was initiated with the agreement to invite the director of the Division on Aging of the State Department of Health and Social Services to future Division meetings.

The Division chairman, Dr. Craig Larson, Milwaukee; Dr. George M. Shinners, Green Bay; and Dr. Edward F. Banaszak, Menomonee Falls, were present.

State department representatives present were: Dr. R. Frank Reider, Division of Health; and Joseph Kexel, Division of Family Services.

CHP Council Names Subcommittees

The State Advisory Council for Comprehensive Health Planning (CHP) has established four technical subcommittees: Study of Health Services and Needs in Wisconsin, Organization and Administration of Local Public Health Services, Health Manpower in Wisconsin, and A Health Data Center in Wisconsin.

The 37-member Council, appointed by Governor Warren P. Knowles and composed principally of persons not primarily engaged in health activities or services, advises the Bureau of Comprehensive Health Planning of the State Division of Health, Department of Health and Social Services, which is the agency designated by the Governor to administer CHP under Public Law 89–749.

The following persons have been appointed to the subcommittees:

STUDY OF HEALTH SERVICES AND NEEDS IN WISCONSIN

Torre Allegrezza, Curative Workshop, Milwaukee
Michael Arra, DDS, Sec. Dental Health, Madison
Dorothy Hutchison, RN, Univ. of Wis.–Extension Div., Madison
ROBERT E. CALLAN, MD, Gen. Pract., Milwaukee
Mary Julia Denton, Div. Family Services, Madison
Charles Hill, Dept. of Local Affairs & Develop., Madison
G. W. HILLIARD, MD, Gen. Surg., Milwaukee
J. G. JAMIESON, MD, Gen. Pract., Racine
Symond R. Gottlieb, Hosp. Area Plan. Com., Milwaukee
J. W. MANIER, MD, Internal Medicine, Marshfield
THOMAS C. MEYER, MD, Univ. of Wis. Med. School, Madison
Edward J. Pfeifer, Div. Voc. Rehab., Madison
K. H. RUSCH, MD, Div. of Mental Health, Madison
B. J. Shannon, OD, Optometrist, Mauston
Earl R. Thayer, State Medical Society of Wis., Madison
A. Rowland Todd, Welfare Council, Madison
Harvey Wirth, Bur. Environ. Health, Madison
Gregory L. Griffin, Health Plan. Council, Madison

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L. J. English, DDS, Arcadia
Kirby Hendee, Stevens Point
PAUL B. MASON, MD, Sheboygan
Mrs. James D. Swan, Elkhorn
Albert L. Twesme, Whitehall
Warren R. Von Ehren, Madison

Secretary

Vincent F. Otis (from Staff)

ORGANIZATION AND ADMINISTRATION OF LOCAL PUBLIC HEALTH SERVICES

Jerome Foy, Mental Health Div., Madison
C. M. FLANAGAN, MD, Otolaryngology, Fond du Lac
LYLE FRANZEN, MD, Waukesha Co. Health Dept.
C. K. KINCAID, MD, City Health Commissioner, Madison
EDWIN LARKIN, MD, Bur. Local Health Serv., Madison
Karl Mohr, City Health Officer, Green Bay
LEIGH ROBERTS, MD, Univ. of Wis. Dept. of Psychiatry, Madison
James H. Sullivan, Wis. Regional Med. Program, Milwaukee
Norman Whitford, Winnebago Co. Welfare Dept., Oshkosh
HAROLD E. SORENSEN, MD, Orthopedic Surgery, Eau Claire
Symond R. Gottlieb, Hosp. Area Plan. Com., Milwaukee
Gregory L. Griffin, Health Plan. Council, Madison

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Creigs C. Beverly, Milwaukee
Lowell Frautschi, Madison
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George F. Kress, Green Bay
Harris Mahan, Superior
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Douglas Weiford, Madison

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HEALTH MANPOWER IN WISCONSIN

ROBERT COYE, MD, Univ. of Wis., Madison
W. P. CROWLEY, JR., MD, Internal Med., Madison
Helen DeBardeleben, Div. Mental Hyg., Madison
R. W. EDWARDS, MD, Gen. Pract., Richland Center
Paul Fleer, Patient Care Pract., Madison
John Biddick, Div. Voc. Rehab., Madison
Roger Hamilton, Wis. Hosp. Assoc., Madison
Helen Bunge, RN, UW Sch. of Nursing, Madison
C. A. OLSON, MD, Gen. Pract., Baldwin
Bea Palen, Voc., Tech., & Adult Educ., Madison
Roy Ragatz, Wis. Regional Med. Prog., Madison
Adele Stahl, RN, Div. Nurses, Madison
Francis Walsh, State Employ. Serv., Madison
Symond R. Gottlieb, Hosp. Area Plan. Com., Milwaukee
Gregory L. Griffin, Health Plan. Council, Madison

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JOHN S. HIRSCHBOECK, MD, Milwaukee
Mrs. R. B. Horschak, La Crosse
William A. Jahn, Milwaukee
Grant Larned, Milwaukee
Wesley J. Mooney, Racine
Valencia N. Prock, Madison

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Gerry Halverson (from Staff)

A HEALTH DATA CENTER IN WISCONSIN

L. E. Aase, Bur. Health Statistics, Madison
Donald Benn, Div. Mental Hyg., Madison
Kenneth Dueker, PhD, Univ. of Wis., Madison
David Gustafson, PhD, Wis. Regional Med. Prog., Madison
Paul H. Kusuda, Dept. Health and S.S., Madison
PAUL G. LA BISSONIERE, MD, Internal Med., Wauwatosa
M. F. PURDY, MD, Int. Med., Janesville
Alfred A. Rimm, PhD, Marq. Med. Sch., Milwaukee
Peter J. Sheldon, Marq. Univ. Dept. of Sociol., Milwaukee
Phillip Sundal, PhD, Dept. Local Affairs & Develop., Madison
P. E. WAINSCOTT, MD, Obstetrics–Gynecology, Menasha
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George F. MacKenzie, Oxford
John W. Melcher, Madison
Ronald Stevens, Eau Claire

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James D. White (from Staff)

INDEX VOL. 67, 1968

The symbols used to indicate in which department the matter indexed appears are as follows: "E", Editorial; "PP", President's Page; "CT", comments on treatment; "SDH", State Division of Health; and "TD", therapeutic dilemmas. These symbols precede page number. When a double number such as "2–37" appears, the first number refers to the month of issue; the second number to the page. When a single number such as "385" appears, the number refers to the scientific section which is numbered consecutively through the 12 issues of the volume. The following table indicates the page numbers of the scientific section for each month.

MONTH	PAGES	MONTH	PAGES	MONTH	PAGES
January	1–112	May	245–286	September	403–508
February	113–146	June	287–316	October	509–546
March	147–204	July	317–360	November	547–584
April	205–244	August	361–402	December	585–620

AUTHORS OF SCIENTIFIC ARTICLES

Page

Apfelberg, David B., Milwaukee 405
Barron, Jesse J., Minneapolis, Minn. 113, 114
Bauer, Detterick, Milwaukee 375
Beckman, Harry, Milwaukee 128, 163, 223, 260, 300, 334, 382, 418, 524, 561, 603
Bennett, Maxine E., Madison 585
Cox, Paul M., Jr., Madison 558
Cripps, Derek J., Madison 387
Crocker, Laurence G., Madison 254
Crumpacker, Margaret, Madison 514
Curtis, Arthur C., Ann Arbor, Mich. 519
Dean, George W., Milwaukee 547
Diamond, R. A., Minneapolis, Minn. 216
Doherty, Joseph M. (DDS), Madison 599
Duffy, John C., Rochester, Minn. 125
Forster, Francis M., Madison 121
Fritz, Richard D., Milwaukee 378
Ellison, Edwin H., Milwaukee 209
Elmore, James L., Durham, N. C. 117
Engbring, Norman H., Milwaukee 265
Evrard, John R., Milwaukee 534
Glennon, Joseph A., Madison 341
Gomez, Faustino, Marshfield 596
Goswitz, John T., Manitowoc 205
Greist, John H., Madison 219, 256
Gutgesell, Howard P., Jr., Madison 251
Habeck, Edgar A., Milwaukee 374
Hofmeister, Frederick J., Milwaukee 509
Jacobs, Edmund B., Madison 409
Jaeschke, Walter H., Madison 361
Jefferson, James W., Madison 321
Johnson, Daniel F., Madison 424
Kennan, Alfred L., Madison 424
Kersting, David W., Milwaukee 550
Kiekhofer, William, Madison 514
Korst, Donald R., Madison 566
O'Leary, William, Milwaukee 509
Leasum, Robert N., Osseo 126
Levinson, Carl J., Milwaukee 317
Lawton, Ben R., Marshfield 209
Levy, Donald M., Milwaukee 327, 375
Litin, Edward M., Rochester, Minn. 125
Lohrenz, Francis N., Marshfield 209
Madison, Frederick W., Milwaukee 378
Martens, Jacob H., Madison 585
Maurer, William, Milwaukee 378
Mallin, Sanford R., Marshfield 209
McLeod, Paul A., Madison 154
Middleton, William S., Madison 289
Pagedas, Thomas, Milwaukee 147
Pellegrino, Ernest A., Jr., Madison 413
Perry, Harold O., Rochester, Minn. 245
Peters, Leo M., Milwaukee 374
Pfefferkorn, Ethan D., Marshfield 294
Polacek, Michael A., Milwaukee 147
Rose, Harold D., Milwaukee 168, 550
Sarto, Gloria E., Madison 514
Schorr, William F., Marshfield 596
Schultz, Alwin E., Madison 514
Skinner, H. Grant, Madison 534, 558
Skor, Robert B., Madison 361
Snider, Gordon L., Milwaukee 229
Somani, Pitambar, Milwaukee 296
Spellacy, William N., Minneapolis, Minn. 159, 216
Stoll, William M., Green Bay 403
Strawn, E. Y., Milwaukee 522
Teasley, Jack L., Milwaukee 405
Thatcher, L. Gilbert, Milwaukee 530
Tibbetts, Palmer G., Milwaukee 550
Vermund, Halvor, Madison 361, 585
Wang, Richard I. H., Milwaukee 133
Waters, Henry S., Marshfield 294
Welsh, Edwin, Milwaukee 147

All authors are MDs unless otherwise indicated.

AUTHORS OF NONSCIENTIFIC ARTICLES

Becker, C. A. (DD), Racine 136
Cantor, Benjamin J. (BEE, LLB) 36
Chayet, Neil L. (Esq.), Boston, Mass. 33
Cooper, Signe S. (RN), Madison 10–61
Crawford, Helen, Madison 439
Davis, Jean P. (MD), Milwaukee 29
Gilbert, William L. (BSc), Madison 171, 381
Guenther, James (RPh), Marshfield 274
Hirschboeck, John S. (MD), Milwaukee 181
Holtz, Virginia, Madison 439, 574
Falk, Victor S. (MD), Edgerton 241
Jorris, E. H. (MD), Madison 112, 232, 5–40, 6–36, 417, 10–62
Lambertsen, Eleanor C. (EdD, RN) New York 107
Lohrenz, Francis N (MD), Marshfield 274
Miller, Winfield S. (LLB), Oradell, New Jersey 31
Pio, Sister M. (RPh), Marshfield 274
Skinner, H. Grant (MD), Madison 171, 381
Stichter, Wayne E. (Juris Doctor), Toledo, Ohio 38
Towne, Adrian E. (MPH), Madison 29

SCIENTIFIC ARTICLES/ABSTRACTS/INFORMATION

ACNE VULGARIS, Management of (Cripps) CT387
ACTH, parathyroid hormone, and gastrin assays, Multiple endocrine and adenomatosis presenting as Cushing's syndrome and concurrent hyperparathyroidism with massive gastric hemorrhage; case report with (Lohrenz, Mallin, Ellison & Lawton) 209
ADENOMATOSIS presenting, Multiple Endocrine as Cushing's syndrome and concurrent hyperparathyroidism with massive gastric hemorrhage; case report with ACTH, parathyroid hormone, and gastrin assays (Lohrenz, Mallin, Ellison, & Lawton) 209
ADRENERGIC RECEPTORS and the physician CT296
ALDOSTERONISM, Primary (abstract) 560
ANESTHESIA in surgery of the extremities; report of fifty cases, Intravenous (Levy & Bauer) 375
ANTIBIOTIC THERAPY, An approach to (Rose) CT168
ANTIBODY DEFICIENCY and autoimmune reactions, Some clinical expressions of (Middleton) 289

Page

ARTHRITIS of the hip, Femoral head prosthesis for hypertrophic (abstract) ------ 602
ATHEROSCLEROSIS: A metabolic defect or a natural process of aging?, Coronary (Jefferson) ---------- 321
AUTOIMMUNE REACTIONS, Some clinical expressions of antibody deficiency and (Middleton) ---------- 289
BREAST CANCER, Morphological investigation of human (abstract) ---------- 386
BURNS with intensive therapy and exposure, Treatment of (abstract) ---------- 167
CANCER of larynx: based upon clinical staging by the international TNM system, Results of radiation therapy in (Martens, Bennett & Vermund) ---------- 585
CARCINOMA of the breast in children (abstract) 162
CARDIOPULMONARY RESUSCITATION at University of Wisconsin (abstract) -------- 342
CERVICAL CARCINOMA: report of first known case, Evisceration of bowel through the vagina following irradiation for (Habeck & Peters) ---------- 374
CERVICAL PREGNANCY: case report (Strawn) 522
CHEMOTHERAPEUTIC ADJUVANTS, Mechanisms of action of radiotherapy and (abstract) ---------- 328
CHROMOSOMAL DEFECTS in children treated with 1,3-bis (2-chloroethyl)-1-nitrosourea, Prolonged survival of lymphocytes with (abstract) ---------- 222
CLOMIPHENE CITRATE, Induction of ovulation with (McLeod) ---------- 154
CLOMIPHENE CITRATE (MRL-41; Clomid) for the induction of ovulation, Use of, (Treatment of 81 patients in 422 cycles) (Spellacy) ---------- 159
COR PULMONALE, Chronic obstructive lung disease and (Beckman) ----------TD418
CULDOSCOPY at University Hospitals: 1964–1967: review of 100 consecutive cases (Sarto, Crumpacker, Kiekhofer, Schultz) 514
CULPOTOMY, Ovarian pregnancy removed via (Levinson) ---------- 317
CUSHING'S SYNDROME and concurrent hyperparathyroidism with massive gastric hemorrhage; case report with ACTH, parathyroid hormone, and gastrin assays, Multiple endorine adenomatosis presenting as (Lohrenz, Mallin, Ellison & Lawton) -------- 209
CYCLE INJURIES: a comparative study (Pellegrino) ---------- 413
CYCLOPROPANE—The early days at Wisconsin (Gutgesell) ---------- 251
DERMATOLOGY, Flurandrenolone Tape: new therapeutic measure in (Gomez & Schorr) 596
DERMATOMYOSITIS, The many facets of (Curtis) ---------- 519
DISPOSABLE surgical masks, Study of (abstract) 386
DRUG THERAPY in medical practice, Complexities of (Wang) ----------CT–133
DUODENAL DIVERTICULUM; Perforation of a, case report (Waters & Pfefferkorn) ---- 294
DUODENAL HEMATOMA in children, Intramural (abstract) ---------- 218
ELECTRONIC medical design: Tiny flaws can kill (abstract) ---------- 208
EMBOLECTOMY; report of a case with survival, Superior mesenteric arterial (Stoll) ------ 403
EMERGENCY CARE, Legal and moral problems of (Beckman) ----------TD–300
EMERGENCY ROOM PRINCIPLES in limb amputation (Polacek, Pagedas, and Welsh) 147
ERYTHROBLASTOSIS, Rh immunoglobulin and its use in preventing (Johnson & Kennan) ----------CT–424
ESTROGENS from cradle to grave (Beckman) ----------TD–382
EVISCERATION OF BOWEL through the vagina following irradiation for cervical carcinoma; report of first known case (Habeck & Peters) ---------- 374
EXOPHTHALMOS, Enigma of (Kindschi) ------E–572

Page

FAMILIAL DISEASE, rapport, and consent (Lohrenz) ----------E–236
FLUORIDES, Use of dietary (Doherty) -------- 599
FLURANDRENOLONE TAPE; new therapeutic measure in dermatology (Gomez & Schorr) 596
GASTRIN ASSAYS, Multiple endocrine adenomatosis presenting as Cushing's syndrome and concurrent hyperparathyroidism with massive gastric hemorrhage; case report with ACTH, parathyroid hormone and (Lohrenz, Mallin, Ellison & Lawton) ---- 209
GERIATRIC: Neurologic problems of the aged (Forster) ---------- 121
GERIATRIC PATIENT and the physician (Barron) ---------- 114
GERIATRIC PATIENT; case report (Leasum) -- 126
GERIATRIC PATIENT—profile of the aged; introduction (symposium) (Barron) ----- 113
GERIATRIC: Psychiatric morbidity of physicians; summary (Duffy and Litin) ------ 125
GERIATRIC TREATMENT, Physician-patient relationship in (Elmore) ---------- 117
HEARING LOSS: Recent trends and practices, Occupational (abstract) ---------- 373
HEMATOLOGIC DISEASE, Penalties of progress: Drug-induced (abstract) ---------- 549
HEMATURIA, Hereditary (Maurer, Fritz, Madison) ---------- 378
HEMOPHILUS INFLUENZAE meningitis; report of a case in an adult due to a nontypable organism (Crocker) ---------- 254
HEPATOCARCINOMA associated with biliary cirrhosis (abstract) ---------- 595
HERPETIFORMIS: Pemphigus, pemphigoid, or dermatitis (Perry) ---------- 245
HYDATIDIFORM MOLE: report of a case of four recurrences and a review of the literature, Recurrent (Diamond & Spellacy) -------- 216
HYPERTHYROIDISM, Current treatment of (Engbring) ----------CT–265
HYPERPARATHYROIDISM with massive gastric hemorrhage; case report with ACTH, parathyroid hormone, and gastrin assays, Multiple endocrine adenomatosis presenting as Cushing's syndrome and concurrent (Lohrenz, Mallin, Ellison & Lawton) ---- 209
HYPERVENTILATION on precordial T-waves of children and adolescents, Effect of (abstract) ---------- 158
HYPOGLYCEMIC compounds, Oral (Glennon) --CT–341
HYPOTHYROIDISM, Ophthalmopathy with (Dean) ---------- 547
INCOMPETENT CERVIX, Suture reinforcement of the (abstract) ---------- 533
LEUKEMIA in children, Treatment of acute (Thatcher) ----------CT–530
LIDOCAINE anesthesia in surgery of the extremities; report of fifty cases, Intravenous (Levy and Bauer) ---------- 375
LIMB AMPUTATION, Emergency room principles in (Polacek, Pagedas, & Welsh) -- 147
LIMB PROGNOSIS in lumbar sympathectomy (abstract) ---------- 521
LUMBAR SYMPATHECTOMY, Limb prognosis in (abstract) ---------- 521
LUNG DISEASE, Ambulatory management of chronic obstructive (Snider) ----------CT–229
LUNG DISEASE and cor pulmonale, Chronic obstructive (Beckman) ----------TD–418
LUPUS ERYTHEMATOSUS, Systemic (Beckman) ----------TD–603
MALLORY–WEISS syndrome (Beckman) ------TD–163
MAMMAPLASTY, Augmentation (Levy) -------- 329
MENINGITIS: report of a case in an adult due to a nontypable organism, Hemophilus influenzae (Crocker) ---------- 254
MESHGRAFT; case report, Removal of a giant hairy nevus and coverage of the resultant defect with a (Jacobs) ---------- 409
MOLAR PREGNANCY, Significant clinical manifestations of (Hofmeister & O'Leary) ---- 509
MULTIPLE MYELOMA, Current management of (Korst) ----------CT–566
MYOBLASTOMA; report of three cases in the chest wall and review of the literature, Granular cell (Apfelberg & Teasley) ---- 405

Page

MYOCARDIAL DISEASE, Primary (Beckman) ---- TD-128
MYCOPLASMA PNEUMONIAE, Family outbreak of (Cox & Skinner) ---- 558
NEVUS and coverage of the resultant defect with a meshgraft; case report, Removal of a giant hairy (Jacobs) ---- 409
OPHTHALMOPATHY with hypothyroidism (Dean) ---- 547
ORGAN SYSTEMS, Considerations in the preoperative evaluation of the major (Goswitz) ---- 205
OVARIAN PREGNANCY removed via culpotomy (Levinson) ---- 317
OVULATION with clomiphene citrate, Induction of (McLeod) ---- 154
OVULATION, Use of clomiphene citrate (MRL-41; Clomid) for induction of, (treatment of 81 patients in 422 cycles (Spellacy) ---- 159
OXYTOCICS: Employment and safeguards (obstetrical brief) (Evrard) ---- 534
PARABEN sensitivity: Subtle trouble (abstract) 377
PAPILLOMATOSIS, Juvenile (abstract) ---- 167
PARATHYROID HORMONE, and gastrin assays, Multiple endocrine adenomatosis presenting as Cushing's syndrome and concurrent hyperparathyroidism with massive gastric hemorrhage; case report with ACTH, (Lohrenz, Mallin, Ellison & Lawton) ---- 209
PERICARDITIS, Acute nonspecific benign (Beckman) ---- TD-223
PIGEON BREEDERS' DISEASE: A clinical study of a hypersensitivity pneumonitis (abstract) ---- 423
PLASMA, A statement of the current status of normal (whole, pooled) human ---- 427
PNEUMONIA, Desquamative interstitial (Beckman) ---- TD-260
PNEUMONIA, Lipoid (abstract) ---- 259
PSYCHIATRIC MORBIDITY of physicians; summary (Duffy & Litin) ---- 125
RADIATION THERAPY in cancer of the larynx; based upon clinical staging by the international TNM system, Results of (Martens, Bennett & Vermund) ---- 585
RADICAL NECK dissection, Complications of (abstract) ---- 549
RADIOTHERAPY and chemotherapeutic adjuvants, Mechanisms of action of (abstract) 328
REGIONAL ENTERITIS (Beckman) ---- TD-334
RHEUMATOID ARTHRITIS, Complicated (Beckman) ---- TD-561
RH IMMUNOGLOBULIN and its use in preventing erythroblastosis (Johnson & Kennan) ---- CT-424
SALMONELLOSIS, Surgical implications of (abstract) ---- 340
SPOROTRICHOSIS (Skinner) ---- SDH-534
STATUS ASTHMATICUS (Beckman) ---- TD-524
TETANUS TOXOID booster, Excessive use of (abstract) ---- 568
THYMOMA: Diagnostic and therapeutic aspects (Jaeschke & Vermund) ---- 361
TNM system; Results of radiation therapy in cancer of the larynx; based upon clinical staging by the international (Martens, Bennett & Vermund) ---- 585
TUBERCULOSIS, Clinical spectrum of primary tuberculosis in adults; Convulsion with reinfection in pathogenesis of chronic (abstract) ---- 333
TUBERCULOSIS, Pathogenesis of the sporadic case of (abstract) ---- 127
VIRUSES, Serologic evidence for human infection with adenovirus-associated (abstract) 340
WERNER'S SYNDROME (Tibbetts, Rose & Kersting) ---- 550
WILLIAM OSLER'S education: Part I (Greist) 219
WILLIAM OSLER'S education: Part II (Greist) 256

STATE MEDICAL SOCIETY/ORGANIZATIONAL

ADVERTISING: See *Wisconsin Medical Journal*
AESCULAPIAN STAFF collection ---- 578
AGING, New chairman Division on ---- 435
ANNUAL MEETING, 1968 tentative program ---- 1-45*, 2-13

Page

— 1968, Highlights ---- 4-63
— 1968, Medical art salon ---- 1-53*, 2-29
— 1968, Photography contest ---- 1-51*, 2-28
— 1968, Program ---- 185
— 1968, Summary ---- 309
— 1969, Official call for scientific exhibits ---- 10-13, 11-12, 12-12
— 1969, Photography contest ---- 10-15, 11-14, 12-11
BOOKSHELF, Book reviews ---- 3-64, 4-71, 6-57, 7-66, 8-45, 10-87, 12-60
— Atlas of Diagnostic Techniques and Treatment of Retinal Detachment ---- 10-89
— Development of the Lung ---- 10-88
— Diseases of the Uveal Tract ---- 10-89
— Heritable Disorders of Connective Tissue ---- 8-46
— Medical Pharmacology: Principles and Concepts (third edition) ---- 10-89
— Modern Home Remedies ---- 7-66
— New Hope for your Skin ---- 10-88
— Obstetrics and Gynecology ---- 10-89
— Pathology ---- 7-66
— Pediatric Therapy ---- 7-66
— Surgery of the Breast ---- 8-47
— Symposium on Surgery of the Ocular Adnexa 8-46
— Synopsis of Dermatology ---- 10-87
— Synopsis of Obstetrics ---- 10-89
— The Visual Field ---- 10-88
— Thiamine Deficiency ---- 10-88
BOWL?, Want to ---- 437
CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION ---- 42, 537, 577, 578, 579, 580, 581, 582, 583, 584
— Christmas cards ---- 9-52, 10-68, 579
— Discerning benevolence (Goldstein) ---- 570
— List of officers and board of trustees ---- 98, 506, 584
CHARTER LAW of medical societies in Wisconsin ---- 62
COIN COLLECTION stolen from Society headquarters ---- 5-28
COMMENTS ON TREATMENT: New co-editor, Richard I. H. Wang, PHD, MD, Milwaukee ---- CT-134
COMMISSION ON SCIENTIFIC MEDICINE elected Dr. Edgar S. Gordon chairman ---- 8-28
CONSTITUTION and bylaws ---- 63
CORRESPONDENCE: See Letters
COUNCIL advises MDs . . . guidelines for professional courtesy ---- 436
— award, Recipients of ---- 97
— chairman, Dr. E. J. Nordby, New ---- 309
— committees: 1967-1968, Component ---- 92
— committees: 1967-1968, SMS ---- 93
— meetings, Minutes of
Madison, Nov. 4, 1967 ---- 110
Madison, Mar. 9-10, 1968 ---- 281
Milwaukee, May 12, 1968 ---- 349
Milwaukee, May 15, 1968 ---- 352
Mackinac Island, Mich., July 19, 1968 ---- 612
Mackinac Island, Mich., July 20, 1968 (Joint, with Commission on Medical Care Plans) ---- 614
Madison, Oct. 19-20, 1968 ---- 615
COUNCILOR DISTRICTS, Map of ---- 88
COUNTY MEDICAL SOCIETIES, List of officers ---- 2, 2-8, 503
— proceedings ---- 2-43, 3-53, 4-51, 5-37, 6-33, 7-37, 8-35, 9-43, 10-73, 11-55, 12-30
Ashland-Bayfield-Iron ---- 4-51, 8-35, 11-56
Barron-Washburn-Sawyer-Burnett ---- 11-56
Brown ---- 3-53, 4-51, 7-37
Calumet ---- 6-34
Chippewa ---- 3-53, 6-34, 10-73, 11-55, 12-30
Columbia-Marquette-Adams ---- 11-55
Crawford ---- 2-43
Dane ---- 2-43, 3-53, 8-35, 9-43, 10-73, 12-30
Dodge ---- 2-43
Douglas ---- 2-43, 3-53, 6-34, 7-37, 8-35, 11-56
Eau Claire-Dunn-Pepin ---- 5-37
Green Lake-Waushara ---- 4-51
Kenosha ---- 3-53, 4-51, 5-37, 11-55, 12-30
La Crosse ---- 11-55
Lafayette ---- 7-37
Manitowoc ---- 6-33
Marathon ---- 6-34, 8-35, 11-55
Milwaukee ---- 2-43, 6-34
Monroe ---- 9-43
Oconto ---- 5-37

Page
Oneida–Vilas 2–43
Outagamie 2–44, 4–51, 7–37, 9–43
Racine 2–44, 9–43, 11–55
Richland 2–44, 3–53, 9–43
Rock 5–37, 9–43
Sauk 11–56
Trempealeau–Jackson–Buffalo 4–51
Vernon 11–55
Walworth 2–44, 3–53, 4–51, 7–37
Washington 6–34
Waukesha 2–44, 3–53, 6–34, 9–43, 11–55
Waushara–Green Lake 12–30
Winnebago 3–53, 6–33, 8–35, 9–43, 11–56
Wood 5–37
EDITORIALS 106, 141, 175, 236, 271, 305, 307, 344, 398, 426, 536, 570, 610
— Accurate Recognition (Goldstein) 142
— Are We Well Fed (reprint) (Enloe) 346
— Blue Foundations (Goldstein) 610
— Carl N. Neupert, M.D. (Crownhart) 307
— Case for Pace, The (Goldstein) 426
— Commodity and the Cost, The (Goldstein) 305
— Conference on Quackery (Goldstein) 142
— Deep Footprints 345
— Discerning Benevolence (Goldstein) 570
— Ductus Issue, The (Goldstein) 536
— Educational Opportunity 537
— Enigma of Exophthalmos, The (Kindschi) 572
— Familial Disease, Rapport and Consent (Lohrenz) 236
— Honorable Oscar Rennebohm, The 572
— Medical Public Utility (Goldstein) 141
— New Combo 571
— Paradox and Perspective in the Practice of Medicine (Kindschi) 344
— Peripatetic Practitioner, The (Gerol) 106
— Perplexing Doctrine (Goldstein) 271
— Postal Abuse (Goldstein) 176
— Relentless Futility (Goldstein) 175
— Traduction of the Clinical Laboratory (Goldstein) 398
ELECT 20 MDs to Society posts 316
FIFTY-YEAR CLUB members honored 7–29
GRIEVANCE COMMITTEE, Have a complaint? See your (James) 343
GORDON, EDGAR S. (MD) elected chairman Commission on Scientific Medicine 8–28
GUNDERSEN AWARD, Dr. Flavio Puletti receives second annual Gunnar 11–50
GWARTNEY, RICHARD H. (MD) donation of artwork to Section on Medical History 4–38
HANDICAPPED contest, Society supports 5–27
HOUSE OF DELEGATES actions cover birth to death 315
— adopts 3-part program for blood testing of drinking drivers 309
— President's message to (James) 287
— Reports and proceedings of May 1968 session (supplement) 447
— seek ruling on sterilization 310
— urges law on implied consent 310
IN-DEPTH teaching programs 438, 10–9, 11–11
JAMES, WILLIAM D. (MD) installed as new president 315
— new president (biography and picture) 269
KELLEY, J. H., donation to Museum 10–65
LARSON, CRAIG (MD), New chairman Division on Aging 435
LETTERS 144, 177, 237, 273, 347, 400, 538, 611
— A Volunteer for Honduras 237
— Can You Help in Coma Study? 238
— Carcinoma of the Lip—Treatment by surgery or radiation? 177
— Medical School Graduate Pleased 538
— New SK&F Services Catalog 538
— Nurses Group Appreciates Concern 611
— Official Physiatrist Group 144
— Opportunities With Peace Corps 347
— Organized Medicine Defended 273
— Ostomy Association Offers Help 538
— Peripatetic Practitioner 237
— "Publish or Perish" 611
— Spears Chiropractors of Denver 400
— Suicide Prevention 144
— Urges Registration of Hemophiliacs 347
— Vietnam Volunteer Praised 144
LICENTIATES, Recent Wisconsin 1–61*
MAP, Locations of SMS buildings in Madison 1–71*

Page
MASON, PAUL B. (MD) president WPS charge card corp. 539
— Society representative for Comprehensive Health Planning 395
MASSOPUST, LEO C., Presidential citation awarded 314
MEDICAL ART SALON: See Annual Meeting
MEDICAL ASSISTANTS charter becomes part of medical society exhibits 6–23
MEDICAL GREEN SHEET 309, 353, 389, 431, 539, 577, 12–33
MEDICAL HISTORY award; Dr. Leland C. Pomainville honored by CES Foundation 583
MEDICAL STUDENT FORUM 146, 179, 240, 279, 308, 348, 402, 10–63, 573
MEDICAL STUDENTS, Funds still in short supply for loans to 578
— Houghton award to two senior 315
— Medical school graduate pleased (letter) 538
— Microscopes for loan to 579
— Society president sets up statewide medical award 4–39
— were guests of SMS, Senior 311
MEMBERS, List of SMS 75
MUSEUM OF MEDICAL PROGRESS and Stovall Hall of Health 4–40, 4–66, 5–27, 5–28, 5–29, 268, 6–22, 360, 7–28, 8–26, 8–28, 507, 9–39, 10–65, 581
NORDBY, E. J. (MD); Deep Footprints (editorial) 345
— New Council chairman 309
OBITUARIES, Deceased physicians 2–71, 3–65, 4–67, 5–59, 6–61, 7–63, 8–43, 9–57, 10–81, 11–65
— Bachhuber, Harold A., Sauk City 10–81
— Bailey, Douglas W., Milwaukee 2–71
— Baker, Rowe G., Tomahawk 9–57
— Bauer, William W., Chicago 2–71
— Bemis, Ira M., Batavia 9–57
— Bertolaet, Elmer E., West Allis 11–65
— Biller, Saul E., Milwaukee 8–43
— Bingol, Orhan, Walworth 7–63
— Blank, Henry, Milwaukee 4–67
— Connell, F. Gregory, Oshkosh 8–43
— Corcoran, Cornelius J., Milwaukee 2–71
— Davin, Charles C., Kenosha 9–57
— Dean, James P., Madison 10–81
— Dernbach, George P., New London 7–63
— Dunham, Charles T., Racine 4–67
— Dubinski, Marie Kersten, Stevens Point 4–67
— Edmondson, Campbell C., Waukesha 7–63
— Faulds, James D., Abrams 2–71
— Felton, William C., Appleton 2–71
— Fowler, Paul H., Plain 11–65
— Gorenstein, Lester M., Fort Meyers, Fla. 5–59
— Gregory, Lawrence W., Manitowoc 4–67
— Grigsby, R. O., Ashland 2–71
— Guardalabene, Vito, Milwaukee 11–65
— Haberland, John E., Milwaukee 2–71
— Hagerty, Warren T., Green Bay 9–57
— Hemmingsen, T. Charles, Racine 10–81
— Holbrook, Arthur T., Milwaukee 7–63
— Houghton, John H., Wisconsin Dells 5–59
— Hudek, D. F., Bloomer 3–65
— Hurwitz, Sidney P., Milwaukee 10–82
— Kampmeier, Arthur J., Milwaukee 4–67
— Kasak, Michael, Milwaukee 4–67
— Kasten, Harry E., Beloit 11–65
— Kehl, Kenneth C., Racine 5–59
— Kinsman, Frank C., Eau Claire 6–51
— Kolb, Frederick K., Howards Grove 2–71
— Kozelka, A. W., Two Rivers 4–67
— Knutson, Oscar, Osseo 5–59
— Kronzer, J. J., Oshkosh 2–71
— Kruszewski, Joseph L., Milwaukee 2–71
— LaHam, Jamil T., Winneconne 10–81
— Lahmann, Albert H., Milwaukee 3–65
— Lewis, Charles N., Madison 6–51
— Malin, George F., La Crosse 6–51
— Malnekoff, Benjamin J., Milwaukee 4–67
— Martens, Earl W., Milwaukee 6–51
— Mastalir, Lester O., Milwaukee 4–67
— Mauel, Nicholas, Cashton 2–71
— Miller, E. A., Clintonville 2–71
— Miller, Howard Clare, Whitewater 4–67
— Moore, Robert M., Frederic 2–71
— Murphy, Francis D., Wauwatosa 9–57
— Neacy, Clement F., Palos Verdes, Calif. 5–59
— Neupert, Carl N., Madison 7–63

Page

— Nowack, Louis H., Watertown 2–71
— Peelen, Alfred W., Milwaukee 6–51
— Pfeifer, Fred J., New London 2–71
— Potter, Roy P., Marshfield 10–82
— Potts, Willis J., Sarasota, Fla. 7–63
— Reinke, Christoph C., Milwaukee 5–59
— Rettig, Henry R., Milwaukee 11–65
— Rice, Carroll, Delavan 10–81
— Rybak, Frank S., Madison 4–67
— Schubert, Frank J., Milwaukee 3–65
— Schweitzer, George J., Milwaukee 2–71
— Shewalter, George M., Clearwater, Fla. 6–51
— Stampar, Desanka, Madison 5–59
— Stebbins, George G., Madison 8–43
— Stebbins, Walter W., Madison 5–59
— Van Valin, Erwin C., Sussex 4–67
— Walker, John P., Lincoln, Ill. 11–66
— Walsh, James D., Mauston 2–71
— Wilkinson, John J., Milwaukee 8–43
— Wright, Robert S., Racine 2–71
OFFICERS, COUNCILORS, DELEGATES AND ALTERNATES TO AMA: 1967–1968 89
OFFICERS OF SCIENTIFIC SECTIONS, List of 94
OPEN PANELS, SMS mails 47,000 3–37
OPHTHALMOLOGY, Section on 145, 180, 239, 280, 6–35, 7–41, 8–39, 9–47, 10–75, 11–63, 12–31
PAST PRESIDENTS, List of 96
PHOTOGRAPHY CONTEST: See Annual Meeting
PHYSICIAN NEWS 2–33, 3–39, 4–47, 5–31, 6–25, 7–35, 8–31, 9–49, 10–67, 11–45, 12–23
PHYSICIANS EXCHANGE 1–67*, 2–82, 3–66, 4–72, 5–62, 6–58, 7–68, 8–48, 9–60, 10–90, 11–74, 12–61
PLACEMENT SERVICE aids doctors and communities 103
PRESIDENTIAL CITATION awarded Leo C. Massopust 314
— Recipients of 97
PRESIDENT, Dr. James installed as new 315
PRESIDENT'S PAGE 104, 139, 173, 233, 269, 343, 397, 425, 535, 569, 609
— A Daily Opportunity to "Set the Record Straight" (James) 397
— A Successful Venture with Youth (James) 569
— Continuing Education—a must (James) 609
— Education is Key to Health Quackery Menace (James) 425
— Have a Complaint? See Your Grievance Committee (James) 343
— Leaves of Change (James) 535
— Our Aims Are Our Duties (Kief) 104
— Quo—Vadis, The Professions (Kief) 233
— The Blue Plans—A Plea (Kief) 139
— The Corson Report (Kief) 173
— The New President: William D. James 269
PULETTI, FLAVIO (MD) receives second annual Gunnar Gundersen award 11–50
REGIONAL REPRESENTATIVES, Membership urged to use services of 358
SAFE TRANSPORTATION names subcommittees and organization, Commission on 4–39
SECTION ON MEDICAL HISTORY 4–38
SECTION ON OPHTHALMOLOGY: See Ophthalmology
SERVICES to members 74, 505
— to physicians and the public 1–56*
SOCIETY RECORDS 1–55*, 2–79, 4–69, 6–53, 7–61, 9–58, 10–84, 11–68
SPEAKERS SERVICE, Attention county society program chairmen 438, 10–73
SPECIALTY SOCIETIES, List of presidents and secretaries of Wisconsin 95
— See also Medicolegal/Socio-economic/Ancillary
STANDING COMMITTEES: 1967–1968 90
TELEPHONE NUMBER of SMS, New 7–32
— system installation delayed by strike 5–29
TERRITORIAL LEGISLATION, creating 62
STATE MEDICAL SOCIETY activities 4–39, 5–27, 6–23, 7–29, 8–27, 9–39, 10–65
WISCONSIN MEDICAL JOURNAL, List of editorial staff, editorial board, and commission on scientific medicine 1
— List of 1967 advertisers 1–65*
— Principles of advertising 1–66*
— Publication information 1–6*, 2–7, 3–7, 4–7, 5–7, 6–7, 7–6, 8–6, 9–6, 10–6, 11–6, 12–6

Page

— Wang, Richard I. H. (PhD, MD) new co-editor of Comments on Treatment page 134
WISCONSIN PHYSICIANS SERVICE 1–4*, 2–18, 3–69, 4–75, 286, 6–61, 7–71, 8–51, 9–55, 10–93, 11–72, 12–58
— charge card corp. formed; Dr. Mason president 539
— enrolls at U. W. 391
— How to file claims for persons eligible for Railroad Medicare and the Wisconsin Medical Assistance Program (Medicaid) (Medicaid report no. 2) 619
— Postpayment financing of health care expenses initiated by 396
— Postpayment plan readied by 437
— provides student coverage 438
— reports strong growth in 1967 315
— to host Midwest Finance Seminar 540
— to increase premium rate on Medicare-PLUS $15,000 541
— When care furnished to ECF patients can be covered by Medicare (Medicare report no. 5) 429
WISCONSIN WORK WEEK OF HEALTH, 6th annual 431, 432, 433, 9–39, 541, 542, 543
— Successful venture with youth (James) 569
WOMAN'S AUXILIARY, Christmas cards 9–52, 10–68, 579
— List of officers and directors 95
— 1968 annual meeting program 188
— 1968 medical art salon 1–53*, 2–29
— Report to House of Delegates (supplement) 493
— has medical careers day April 27 5–28

MEDICOLEGAL/SOCIO–ECONOMIC/ANCILLARY

ABANDONMENT CHARGE, Are you risking an? (Chayet) 33
ABORTIFACIENTS, Sale of contraceptives and 35
ABORTION and the Wisconsin law 55
ABUSED CHILD law, The 27
ADOPTIONS; Refer child placement cases to these agencies 59
ADVERTISING: See State Medical Society
ALLIED PERSONNEL in total health care, Clarify role of 313
AMA convention badges to Museum 8–28
— Council; Dr. William B. Hildebrand elected to 359
— Educational opportunity E–537
— field representative, New 359
— headquarters?, Want to tour 144
— president speaks 316
— Purposes and responsibilities of the PP–104
— trustees; Dr. L. O. Simenstad reelected to 359
— volunteer physicians for Vietnam 244
— warns, Simple obesity not simple 540
ANCILLARY: See also Paramedical
ANNIS, EDWARD R. (MD); Organized medicine defended (letter) 273
ATHLETIC COMPETITION, Develop health guide for junior-senior high 436
BASIC SCIENCE BOARD, Wisconsin 102
BIRTHS, File certificate for 61
BLINDNESS, Law requires silver nitrate to prevent 35
BLOOD TESTS, Blood grouping tests for identification 28
BLOOD ALCOHOL TESTING, M.D. guidelines for highway accident 312
BLOOD TESTING of drinking drivers, House of Delegates adopts 3-part program 309
BLUE FOUNDATIONS (Goldstein) E–610
BLUE PLANS—a plea, The (Kief) PP–139
BODIES or parts, Statute authorizes gifts of human 61
BOOKS: See Bookshelf (State Medical Society)
CANCER CURES; Relentless futility (Goldstein) E–175
CARCINOMA of the lip; Treatment by surgery or radiation? (letter) 177
CARDIAC in industry, Begin research on 580
CAREERS DAY April 27, Auxiliary has medical 5–28
CAREER efforts, Urge 316
CHAMBER briefs, A review of developments of interests of the Wisconsin business community (reprint) 143

Page

CHAPTER 301, Laws of 1959; Inspection of physician and hospital records; interpretation of ---- 45
CHARGE CARD: See Postpayment Plan
CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION: See State Medical Society
CHARITY begins at home, Foundation ---- 580
CHILD placement agencies, Refer to these ---- 59
CHIROPRACTIC; Postal abuse (Goldstein) ----E-176
—— services under Title XIX (Medicaid) voted by Wisconsin Public Welfare Association 360
CHIROPRACTORS ---- 311
CLARK, PAUL F. (PhD); Bacteriologist honored 310
CLINICAL LABORATORY, Traduction of the (Goldstein) ----E-398
CODE SYSTEM by pharmaceutical companies --E-142
COMMITMENT proceedings, Registration for reference work on ---- 60
COMMUNICABLE DISEASES, Report to Division of Health ---- 61
COMMUNITY HEALTH WEEK, Medical societies urged to promote local ---- 432
COMPREHENSIVE HEALTH CARE coverage -- 311
COMPREHENSIVE HEALTH PLANNING, Leaves of change (James) ----PP-535
—— Miracle or menace?, A report on plans and action in Wisconsin ------389, 390, 391, 392, 393, 394, 395, 396
—— statewide meetings scheduled for ----540, 541
CONSENTS for treatment of a minor ---- 28
CONTRACEPTIVES and abortifacients, Sale of 35
CORSON REPORT, The (Kief) ----PP-173
COUNCIL ON HEALTH, Memorial statement of the Council on Health in memory of John H. Houghton, M.D., a member of the ---- 401
—— Dr. Ray R. Rueckert named to ---- 359
COUNTY HEALTH COMMITTEES face challenge (Jorris) ----SDH-62
COUNTY MEDICAL SOCIETIES: See State Medical Society
COUNTY SOCIETY program chairmen, Attention ---- 438
CYTOLOGY program reveals mouth cancer, Oral (Jorris) ----SDH- 5-40
DELEGATION OF DUTIES and functions to nurses, Physicians' guidelines for ---- 54
DENTISTRY in hospitals, Joint Commission standards for ---- 48
DIAL ACCESS medical library ---- 2-40
DREW, FRANK E. (MD) reappointed director Wisconsin Regional Medical Program --- 435
DRINKING DRIVERS, House of Delegates adopts 3-part program for blood testing of ---- 309
DRIVER IMPAIRMENT, Medical evaluation of 18
DRUG ABUSE information ---- 438
DRUGS at reduced cost of hospital patients, High quality (Guenther, Pio & Lohrenz) 274
—— Control of LSD ---- 71
—— subject at Wisconsin Work Week of Health ----431, 541
—— subject to narcotic laws ---- 53
EDITORIALS: See State Medical Society
EDUCATION—a must, Continuing (James) ----PP-609
EMERGENCY ROOMS; legal and ethical considerations, Medical staffing and (Stichter) 38
—— May grade hospital ---- 315
EPILEPTICS, Drivers' licenses for ---- 30
—— in Wisconsin, Rehabilitation of (Davis & Towne) ---- 29
EXAMINATIONS, Post mortem ---- 17
EXOPHTHALMOS, The enigma of (Kindschi) --E-572
EXPERT WITNESS, The (Cantor) ---- 36
EXTENDED CARE FACILITY expects from the physician and the nurse, What the (Becker) ---- 136
—— patients can be covered by Medicare, When care furnished to (Medicare report no. 5) 429
FAMILY HEALTH WEEK Nov. 17-23 ---- 543
FLU bug, Watch out for ---- 544
FOUNDATION: See State Medical Society
GENERAL PRACTICE; Urge training of more general MDs ---- 310
GIFT BOOK, The (Holtz) ---- 574

Page

GOVERNMENT REORGANIZATION in Wisconsin ---- 311
GUIDES; Estimating permanent disabilities under Workmen's Compensation ---- 25
—— Find your future in the health field ---- 97
—— Develop health guide for junior-senior high athletic competition ---- 436
—— Physicians' guidelines for delegation of duties and functions to nurses ---- 54
—— M.D. guidelines for highway accident blood alcohol testing ---- 312
—— Professional Courtesy ---- 436
HANDICAPPED children, Milwaukee institutions coordinate medical services for ill and ---- 2-54
—— Library to help visual ---- 432
HANDY, GEORGE H. (MD) explains ideas on health planning law for state ---- 390
HEALTH, State Division of ---- 100
HEALTH AND SOCIAL SERVICES, Department of ---- 99
HEALTH CARE, Clarify role of allied personnel in total ---- 313
—— costs, Cohen calls meeting on ---- 390
—— costs with consumer spending, Dr. Kief compares ---- 314
—— programs for Indians, Outline ---- 434
—— Seven reports get OK of House ---- 314
HEALTH CAREERS brochure ---- 97
HEALTH EDUCATION programs, SMS cites state's 4-H clubs for ---- 2-31
HEALTH EXAMINATION form for State Universities, New ----544, 545, 546
HEALTH INSURANCE grows ---- 435
—— Tax deductibility of health and accident -- 56
HEALTH SURVEYS; Grant to Wisconsin State University—Stevens Point Foundation --- 360
—— Health study offered ---- 434
HEARING, Determining loss of, in Workmen's Compensation cases ---- 26
—— screening, MDs urged to push preschool vision and ---- 435
HEMOPHILIACS, Urges registration of (letter) 347
HILDEBRAND, WILLIAM B. (MD) elected to AMA council ---- 359
HILL, NELS A. (MD) appointed to nursing home council ---- 544
HIRSCHBOECK, JOHN S. (MD), Program coordinator of Wisconsin Regional Medical Program ---- 356
HITCH, OLIVER M. (MD), A volunteer for Honduras (letter) ---- 237
HOPE, Wisconsin doctors support ---- 581
HOSPITAL construction, Dr. Richard E. Housner named advisor for ---- 543
—— construction, Priorities set for ---- 436
—— discharge survey ----SDH-232
—— leaders propose veto power for area planning agencies ---- 396
—— Records retention and inspection, physician and; an interpretation of Chapter 301, Laws of 1959 ---- 43
HOUGHTON, JOHN H. (MD), In memoriam (Goldstein) ----E-235
—— award to two senior students ---- 315
—— Society past president sets up statewide medical award ---- 4-39
—— student loan fund grows ---- 6-23
—— Memorial statement of the Council on Health in memory of, a member of the Council on Health ---- 401
—— student fund continues to grow ---- 8-28
HOUSNER, RICHARD E. (MD) named advisor for hospital construction ---- 543
ILLEGITIMACY, Blood grouping test to determine identification ---- 28
IMMUNIZATION information for international travel, 1967-68 edition ---- 8
—— survey, First-year results, of a Wisconsin infant (Skinner & Gilbert) ---- 381
IMPLIED CONSENT, House urges law on ---- 310
INDIANS, Outline health care programs for---- 434
INDUSTRY, LABOR AND HUMAN RELATIONS, Department of ---- 103
—— What every doctor should know about Workmen's Compensation ---- 20
INSURANCE, Tax deductibility of health and accident ---- 56

Page

—— Problems of a physician's widow ---------- 50
INTENSIVE CORONARY CARE UNIT, Something to think about ---------- 360
IVY, ANDREW C. (MD); Relentless futility (Goldstein) ---------- E-175
JAMES, WILLIAM D. (MD) addresses medical record librarians ---------- 540
JURY DUTY, Physicians exempt from ---------- 19
KELLEY, JAMES O.; Executive secretary, celebrates 30th anniversary with Milwaukee medical society (reprint) ---------- 306
KORKOS, GEORGE J. (MD), Carcinoma of the lip—treatment by surgery or radiation? (letter) ---------- 177
LAWS OF WISCONSIN; Your deadlines and other "musts" ---------- 60
LEGAL PROBLEMS; When a lawyer asks you for a report (Miller) ---------- 31
—— The expert witness (Cantor) ---------- 36
LEGAL RESPONSIBILITIES of the physician-patient-hospital relationship ---------- 51
—— Physician and legal medicine ---------- 49
LEGISLATURE, Directory of members, Wisconsin ---------- 56
LICENSE, Can you practice without a ---------- 19
LOAN funds offered by medical society Foundation, Outline of ---------- 579
—— to medical students, Funds still in short supply for ---------- 578
LSD, Control of ---------- 71
MAIL ORDER solicitation, Physicians being victimized ---------- 396
MALPRACTICE: See also Res Ipsa Loquitur
—— defined ---------- 53
—— The layman's common medical knowledge and experience and res ipsa loquitur (reprint) ---------- 4
—— Problems of a physician's widow ---------- 50
MARCH OF MEDICINE schedule of programs -- 73
MAUTHE, HOWARD (MD), Carcinoma of the lip—treatment by surgery or radiation? (letter) ---------- 177
MEASLES epidemic was dampened if not prevented, The 1966 (Skinner & Gilbert) ---- 171
—— eradication campaigns help reduce incidence to new low ---------- SDH-232
MEDICAID: Wisconsin Public Welfare Association voted in favor of including chiropractic services under Title XIX (Medicaid) ---------- 360
MEDICAL ASSISTANTS choose new president -- 359
MEDICAL COSTS; The commodity and the cost (Goldstein) ---------- E-305
MEDICAL EDUCATION; Summary of findings and recommendations of Task Force on 276
MEDICAL ETHICS of the American Medical Association, Principles of ---------- 72
MEDICAL EVALUATION of driver impairment 18
MEDICAL EXAMINERS, Wisconsin State Board of ---------- 103
MEDICAL MEETINGS ------1-41*, 2-10, 3-22, 4-8, 5-19, 6-8, 7-7, 8-7, 9-7, 10-7, 11-7, 12-7
MEDICAL PRACTICE; Medical public utility (Goldstein) ---------- E-141
—— Paradox and perspective in the practice of medicine (Kindschi) ---------- E-344
MEDICAL PUBLIC UTILITY (Goldstein) ------ E-141
MEDICAL RECORD LIBRARIANS; Dr. William D. James addresses ---------- 540
MEDICAL RECORDS, Physician and hospital records retention and inspection; interpretation of Chapter 301 ---------- 43
MEDICAL REPORTS, When a lawyer asks you for (Miller) ---------- 31
MEDICAL-SCHOOL dean checks up on country doctors (reprint) ---------- 428
MEDICAL SCHOOL expansion, Press for ------ 309
—— given nearly $21,000, Wisconsin ---------- 310
MEDICAL SELF-HELP humanitarian award -- 2-70
MEDICAL SOCIETIES: See State Medical Society
MEDICAL STAFFING of emergency rooms; legal and ethical considerations (Stichter) 38
MEDICAL LIBRARY services in Wisconsin (Crawford & Holtz) ---------- 439
MEDICARE in protest, Nursing home quits ---- 437
—— PLUS $15,000, WPS to increase premium on 541
—— should OK pathologists as MDs ---------- 316

Page

—— When care furnished to ECF patients can be covered by (Medicare report no. 5) -- 429
MICROSCOPES for loan to medical students -- 579
MIDWEST FINANCE seminar, WPS to host --- 540
MILWAUKEE medical society; James O. Kelley, executive secretary, celebrates 30th anniversary with (reprint) ---------- 306
MINOR, Consents for treatment of ---------- 28
MUSEUM: See State Medical Society
NARCOTICS, Annual registration ---------- 53
—— Change of residence ---------- 53
—— In case of death ---------- 53
—— Preprinted prescription blanks ---------- 53
—— registration deadline is July 1 ---------- 295
NEUPERT, CARL N. (MD), A dedicated physician leader in public health (Crownhart) E-307
NICARAGUA expresses appreciation to Society for its assistance ---------- 8-27
—— Wisconsin medicine, agriculture lend helping hand in ---------- 5-27
NURSE, The spectrum of patient care viewed by a (Lambertsen) ---------- 107
NURSES in Wisconsin, Need more "nursing" -- 316
—— to be evaluated, OB course for ---------- 359
—— Physicians' guidelines for delegation of duties and functions to ---------- 54
—— Refresher courses for inactive (Cooper) --- 10-61
NURSING, Wisconsin State Board of ---------- 103
NURSING HOME council, Dr. Nels A. Hill appointed to ---------- 544
—— quits Medicare in protest ---------- 437
NUTRITION; Are we well fed? (reprint) ------ E-346
OBESITY not simple AMA warns, Simple ----- 540
OCCUPATIONAL HEALTH; Small plants get health service help ---------- 359
OFFICE OF ECONOMIC OPPORTUNITY; Central Wisconsin project to recruit MDs ---- 394
—— funds health plan ---------- 392
—— health care for poor in north Wisconsin --- 395
OPHTHALMOLOGY, Section on ------145, 180, 239, 280, 6-35, 7-41, 8-39, 9-47, 10-75, 11-63, 12-31
ORGANIZED MEDICINE defended (letter) --- 273
ORTHOPEDIC FIELD CLINICS, Tentative schedule ----------1-49*, 8-45
OSTOMY association offers help (letter) ------ 538
PACE, The case for (Goldstein) ---------- E-426
PARAMEDICAL/ANCILLARY groups, news about ----------2-51, 3-57, 4-61, 5-51, 6-47, 7-55, 8-41, 9-53, 10-79, 12-32
—— American Medical Technologists ---------- 10-79
—— Dodge County Medical Assistants ---------- 3-57
—— Manitowoc Medical Assistants ---------- 4-63
—— Waukesha County Medical Assistants --3-58, 4-62
—— Wisconsin Anti-Tuberculosis Association ----------3-61, 5-51
—— Wisconsin Heart Association ----------7-55, 8-41
—— Wisconsin Medical Technologists ---------- 4-63
—— Wisconsin Regional Medical Program --5-51, 9-53
—— Wisconsin State Medical Assistants Society 3-57
—— Wisconsin Nurses Association ---------- 8-41
PARTNERSHIP FOR HEALTH ACT: See Comprehensive Health Planning
PATHOLOGISTS as MDs, Medicare should OK -- 316
PATERNITY; Blood grouping test for identification ---------- 28
PATIENT CARE viewed by a nurse, The spectrum of (Lambertsen) ---------- 107
PEACE CORPS, Opportunities with (letter) -- 347
PERIPATETIC PRACTITIONER (letter) ------ 237
—— The (Gerol) ----------E-106
PERLMAN, DAVID S. (PhD) new pharmacy dean at U.W. ---------- 360
PHARMACY dean at U.W., New ---------- 360
—— Wisconsin State Board of ---------- 102
PHOTOGRAPHY CONTEST: See Annual Meeting (State Medical Society)
PHYSIATRIST group, Official (letter) ---------- 144
PHYSICIAN RESPONSIBILITY: A daily opportunity to "set the record straight", (James) ----------PP-397
—— Are you risking an abandonment charge? (Chayet) ---------- 33
—— Delegation of duties and functions to nurses 54
—— Have a complaint? See your grievance committee (James) ----------PP-343
—— Legal responsibilities of physician-patient-hospital relationship ---------- 51

Page

— Post mortem examination 17
— Problems of a physician's widow 50
— Your deadlines and other "musts" 60
— Our aims are our duties (Kief) PP-104
— Quo vadis—the professions (Kief) PP-233
PODIATRISTS, Joint Commission standards governing hospital privileges for 14
POISON information centers 59
POMAINVILLE, LELAND C. (MD) honored by CES Foundation 583
POST MORTEM examination 17
POSTAL ABUSE (Goldstein) E-176
POSTGRADUATE EDUCATION projects under way using new techniques 355
— Also see Medical Meetings
POSTPAYMENT FINANCING of health care expenses initiated by WPS 396
POSTPAYMENT PLAN readied by WPS-Blue Shield 437
— WPS charge card corp. formed; Dr. Mason president 539
PRESCRIPTIONS, preprinted blanks 53
PROFESSIONAL CORPORATION in 1967, The 11
PROFESSIONAL COURTESY, Guidelines for 436
PROFESSIONS, Quo Vadis—The (Kief) PP-233
PUBLIC HEALTH safety is in jeopardy 438
— service laws 311
QUACKERY menace, Education is key to health (James) PP-425
— Conference on 142, 143
— meetings, Urge local 313
RADIATION monitors ready and able (Jorris) SBH 6-36
RECORDS retention and inspection of, Physician and hospital 43
REHABILITATION of the epileptic in Wisconsin (Davis & Towne) 29
RENNEBOHM, OSCAR, The honorable E-572
RES IPSA LOQUITUR, Malpractice—the layman's common medical knowledge and experience and (reprint) 4
— Perplexing doctrine (Goldstein) E-271
ROUSE, MILFORD O. (MD); AMA president speaks 316
RUECKERT, RAY R. (MD) named to health council 359
SCHOOL HEALTH; Develop health guide for junior-senior high athletic competition 436
SELF-EMPLOYED retirement plans, Recent changes in 42
SIMENSTAD, L. O. (MD) reelected to AMA trustees 359
SPEARS chiropractors of Denver (letter) 400
— free clinic and hospital for poor children, inc.; Postal abuse (Goldstein) E-176
SPECIALTY SOCIETY PROCEEDINGS 2-45, 3-56, 4-52, 5-40, 6-36, 7-40, 8-37, 9-45, 10-74, 11-61, 12-30
— Milwaukee Academy of Medicine 2-45, 3-56, 4-52, 5-40, 6-36, 11-61
— Milwaukee Academy of Surgery 4-52
— Milwaukee Gynecological Society 5-40
— Milwaukee Neuro-Psychiatric Society 7-40, 12-30
— Milwaukee Orthopedic Club 2-45
— Section on Anesthesiology 7-40
— Wisconsin Academy of General Practice 6-36, 9-45, 11-61, 12-30
— Wisconsin Allergy Society 2-45
— Wisconsin Anti-Tuberculosis Association 5-51
— Wisconsin Association of PH Physicians 7-40
— Wisconsin Dermatological Society 3-56
— Wisconsin Psychiatric Association 2-45
— Wisconsin Radiological Society 11-61
— Wisconsin Society of Anesthesiologists 2-45, 11-61
— Wisconsin Society of Internal Medicine 11-61
— Wisconsin Society of Pathologists 3-56, 5-40, 9-45, 10-74
— Wisconsin Society of Plastic Surgeons 4-52
— Wisconsin Surgical Society 7-40, 9-45
— Wisconsin Urological Society 4-52, 10-74
SPORTS; Develop health guide for junior-senior high athletic competition 436
STATE BOARDS and commissions, List of officers 102

Page

— Also see under separate headings
STATE MEDICAL SOCIETY OF WISCONSIN; See separate entry
STATE UNIVERSITIES, New health exam form for 544, 545, 546
STERILIZATION; The ductus issue (Goldstein) E-536
— Seek ruling on 310
SUICIDE prevention (letter) 144
SWATZELL, LEON J.; New AMA field representative 359
TAPE LECTURES, New 4-10, 7-65, 8-8
TATTOOS are two too many!, Two 359
TAX deductibility of health and accident insurance 56
— Your deadlines and other "musts" 60
THROMBOEMBOLIC DISEASE is latest WRMP Project 355
TITLE "DOCTOR" in Wisconsin, The right to use the 16
TRAINING of more general MDs, Urge 310
TB association contributes historical exhibit to Museum at Prairie du Chien 5-28
— outpatient clinics in Wisconsin, Services offered by 109
UTERINE CANCER study is first project OK'd, WRMP 355
VACCINE, Combined live virus; New combo (Goldstein) E-571
VIETNAM revisited (Falk) 241
— volunteer praised (letter) 144
VISION and hearing screening, MDs urged to push preschool 435
— in Workmen's Compensation, Determining loss of 26
VOCATIONAL REHABILITATION, State Division of 102
— Physician wanted in 543
VOLUNTARY CONTRIBUTIONS; Discerning benevolence (Goldstein) E-570
WAUSAU CLINIC reports successful transmission of x-ray picture via telephone facilities 4-63
WIDOW, Problems of a physician's 50
WILLING BODIES; Statute authorizes gifts of human bodies or parts 61
WISCONSIN ACADEMY OF GENERAL PRACTICE, annual meeting 541
WISCONSIN ASSOCIATION OF PROFESSIONS; Quo-vadis—the professions (Kief) PP-233
WISCONSIN'S HEALTH: Alcohol involved in most driver deaths (Jorris) 417
— County health committees face challenge (Jorris) 10-62
— Hospital discharge survey (Jorris) 232
— Measles eradication campaigns help reduce incidence to new low (Jorris) 232
— Nursing homes complete first year under Medicare (Jorris) 112
— Nursing homes directory lists 34,267 beds (Jorris) 112
— Oral cytology program reveals mouth cancer (Jorris) 5-40
— Radiation monitors ready and able (Jorris) 6-36
— State backs new tuberculosis program (Jorris) 184
WISCONSIN LEGISLATURE; Directory of members 56
WISCONSIN MEDICAL ASSISTANCE PROGRAM (Title XIX) 311
WISCONSIN MEDICAL JOURNAL: See State Medical Society
WISCONSIN OPTOMETRIC ASSOCIATION 438
WISCONSIN PHYSICIANS SERVICE: See State Medical Society
WISCONSIN REGIONAL MEDICAL PROGRAM —Operational projects (Hirschboeck) 181
— Where is it going? A report on plans and progress in Wisconsin 353, 354, 355, 356, 357, 360, 396, 435, 437
— See also Paramedical/Ancillary
WISCONSIN WORK WEEK OF HEALTH: See State Medical Society
WORKMEN'S COMPENSATION insurance coverage for employes due Jan. 1 6-28, 543
— What every doctor should know about 20

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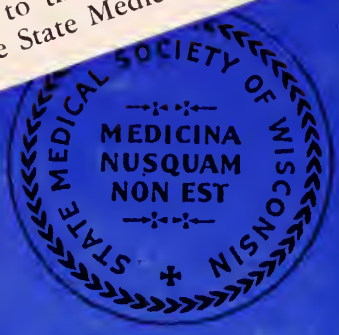
ticles relative to medicolegal, socio-economic matters of direct concern to the physician in relationship to overnmental agencies . . . membership roster, services and structure of the State Medical Society of Wisconsin



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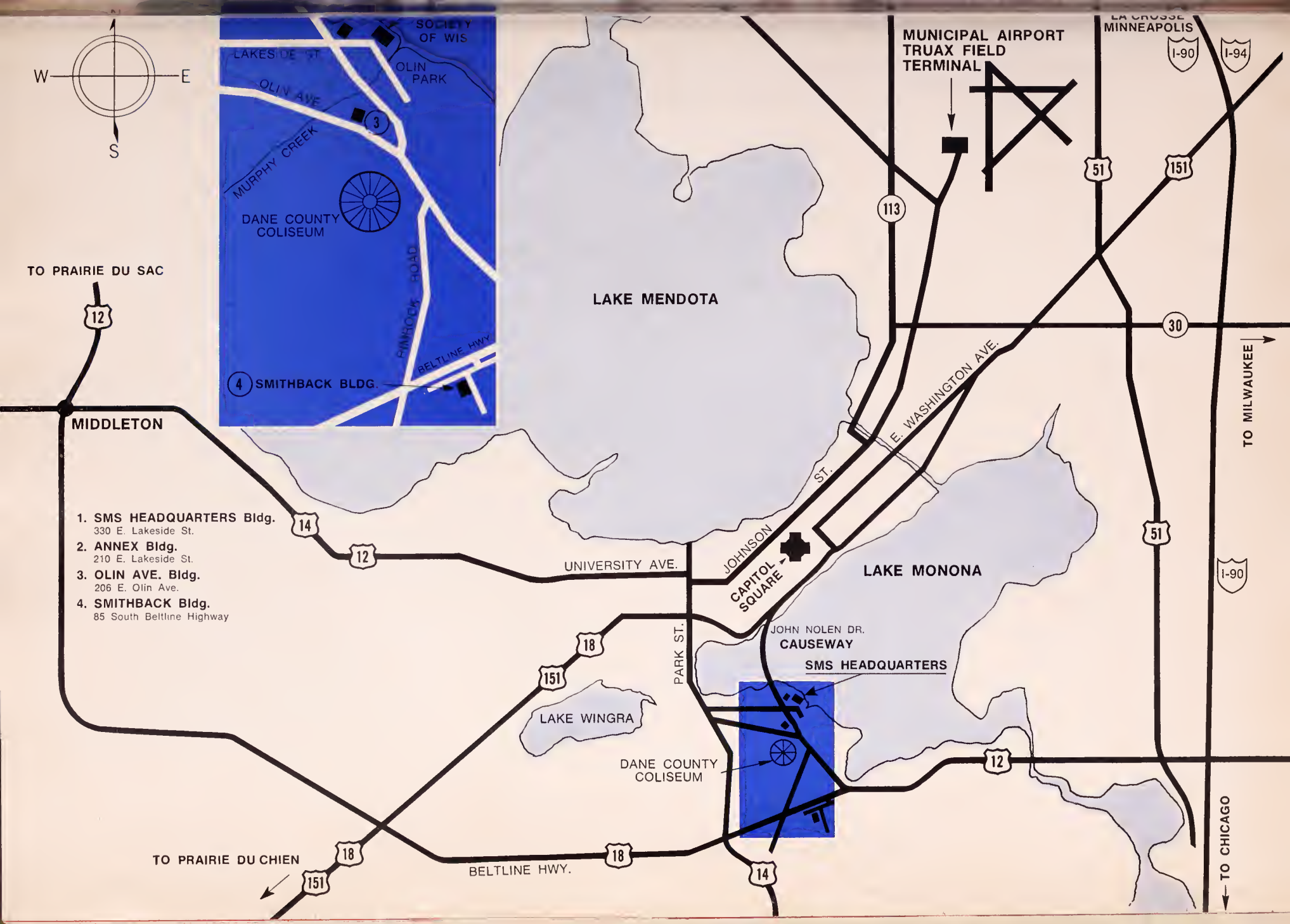
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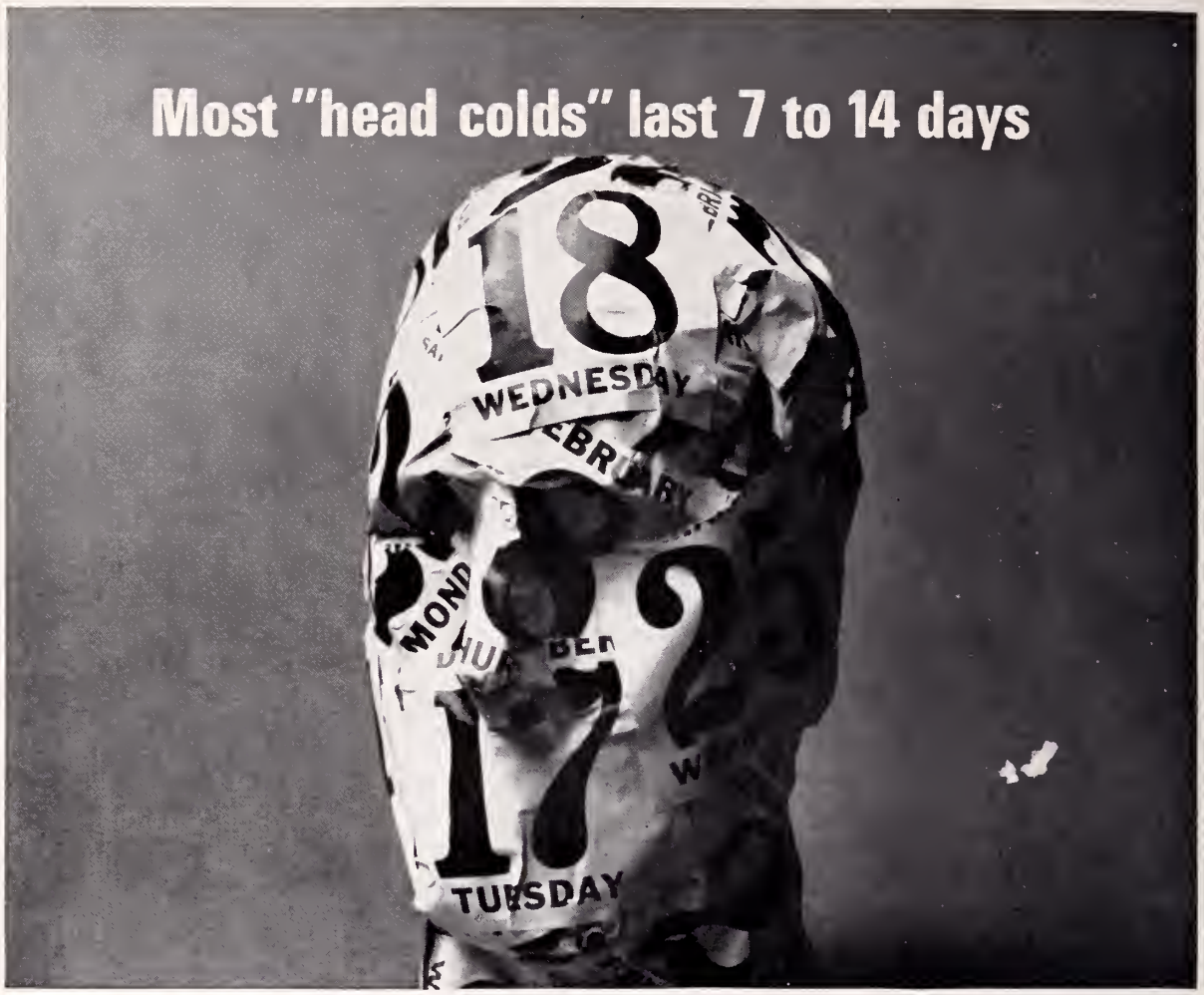

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